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ORIGINAL ARTICLES.

A METHOD OF DETERMINING AMETROPIA BY PRISMATIC REFRACTION.*

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About four years ago this subject first occurred to me, and I have at intervals been engaged with it up to the present time. I venture to believe I can present the instrument to the profession as an accurate one to decide quickly what glasses are required in hypermetropia, myopia, and in astigmatism. It does not concern presbyopia.

The problem is to utilize the refraction of a single prism in determining the glasses required. To illustrate, Fig. 1 is necessary. Let *a* represent a normal eye, placed behind an aperture in the diaphragm *b*; and *d* the base of a glass prism, its apex toward *c*, the truncated apex covering one-half of the said aperture. Let *f* be a circle placed in the axial line *f g*, and *g* the projection of said circle upon the retina. Through the aid of parallel rays of light the true image, *f*, is impressed upon the retina at *g*, and thus *f* is seen without the aid of the prism. But a portion of the rays from *f* are oblique, and reach the prism in the dotted line *f i*; these are refracted towards the base *d* of the prism at *l*, and passing onward through the aperture reach the retina at *m*, and returning from *m* to *l* in the same course they entered the eye and prism. They will appear to be refracted, by a well-known law, from *i* to *n*, or in the angle of deviation of the prism. The circle *n* is, therefore, the counterpart of *m*, and it is the false image of *f*. The refracting power of the prism is so arranged, that at a given distance of the prism from the true circle *f* the inner margins of the true (*f*) and false (*n*) circles shall be tangent in the normal eye. It follows that if the eye be hyperopic these images will be seen apart, and if myopic they will be lapped. If now, in hyperopia, we place the proper convex glass at *o*, and covering the aperture, the images will be rendered tangent; and in the case of myopia, a suitable concave glass at the same point, the lapped images will be rendered tangent. Thus, the glass applied is the measure of the ametropia. The distance from *l* to *f* is fixed. The patient has only to say are the images apart or lapped, and when they become tangent.

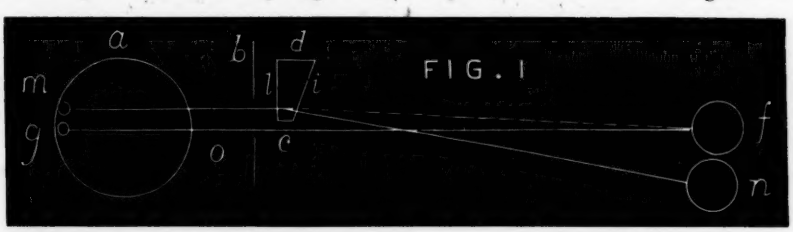


Fig. 1.

The prism is fixed to the diaphragm permanently, and the latter revolves in its plane, so that the prism becomes the measure of the ametropia of any meridian, and hence astigmatism is determined by revolving the diaphragm. If all the meridians are lapped or apart, and the corrective glass be applied, as at *o*, Fig. 1, the circles will touch at each meridian as the prism is being revolved, and hence in such a case there is no astigmatism, but simple general myopia or hyperopia.

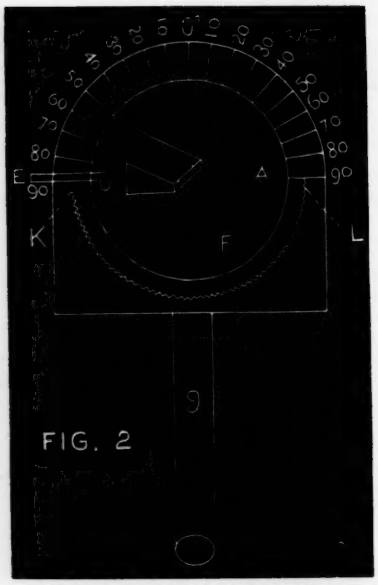
By such a plan the proper glasses can be selected in a few moments, and the result verified by applying the same in the reading of Snellen's test-types.

The construction of the instrument is as follows. (See Fig. 2.)

Figure 2 represents the back surface of the eye-piece. The disc A revolves on its axis. To this disc is secured by clips a prism, the thin edge of which cuts the central opening F obliquely at an angle of 45°, in its diameter. The portion of brass wire, represented at E, is an index which denotes the degrees of the scale, shown on the back surface of the eye-piece, fig. 2. This index also denotes the *particular meridian* under observation; for with this instrument only one meridian of the eye is examined, and each meridian is tested as the index is turned from 90° to 0°, on the right or on the left side of the vertical meridian, fig. 2. The object of the oblique edge of the prism is to prevent the lateral

*This article was originally published in the Cincinnati *Lancet and Clinic*, January 20, 1883. It appears here as several modifications and improvements have been made in the instrument.

FIG. 2.



BACK SURFACE OF EYE-PIECE.

motion of the head of the observer, causing a variation in the position of the false image and thus falsifying the test.

The central opening, *f*, is in front of the flat surface of the prism, and is exactly in the center of the revolving disc, A, Figure 2. Through this the observer, seated, looks at the object circle placed at a proper distance in front of, and from, the eye-piece; K L is a spring clip for holding the trial glasses. This eye-piece is about four mm. thick; *g* is an upright of about one-fourth inch brass gas tubing, securely attached to the eye-piece, and of convenient length.

luster. The four sides, as at *d* of this shallow box, are each 1 inch in width, and the area of the galvanized iron front surface is 12x12 inches; C C represents two hooks to hang this frame securely against a wall, at some point in an office where the object-circle A can be plainly seen by diffused light. The disc with the prism attached to the eye-piece, is shown at B, and the eye of the observer is drawn at C looking through the central opening O at the object-circle A. The rays of light, E F, emanating from the object-circle, pass through the prism and enter the eye of the observer; and by prismatic deflection a false image, A′, of A, the true circle, will be seen on the front surface of the eye-plate *d*; and if the arrangement is perfect and the eye normal, their inner circumferences will touch, as well as the images at the retina of the eye, as shown at C. The eye-piece B, through the upright K, is secured at *f* by a screw to the solid rod *g*, which plays up and down in the gas tube *h*, and is secured at any point by the thumb-screw *i*. The upright, *h*, is screwed into the head of the tripod *l*, and the lower end of each leg of the latter is adapted to a slot in the plates *p p p*, which plates are screwed permanently to the floor. The foot of each leg can be sprung out of the several plates, and thus the tripod can be readily removed or placed in the clips, and set out of the way, or placed in position for use. The height from the floor to A, and from *p* to O, should correspond—about 44 or 45 inches. From the center of A to the center of O should be an imaginary axial line, and the planes of the eye-disc B and of the anterior surface of *d* should be directly opposed and at right angles to this axial-right-line in every meridian. Thus, as the eye-disc M revolves on its axis in an undeviating plane, the inner margin of the false image A′, will touch the inner edge of the true image A, at each meridian,

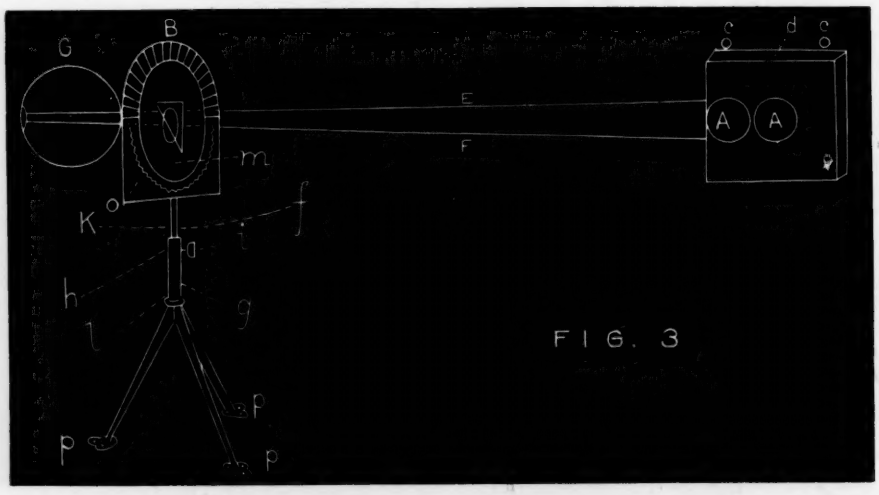


FIG. 3.

Fig. 3 represent the object-circle A, cut out of galvanized iron, behind which rests securely, by clips, a portion of *white opaque glass*, as pure white as possible. The surface of galvanized iron around this *single white circle* is made a deep black color, without

which would not be the case if the eye-disc did not revolve in a true plane.

The measurements are as follows: Diameter of the object-circle, A, 220.5 mm.; diameter of the eye-piece, B 6 inches; diameter of the revolving

disc, A, figure 2, 22 mm.; diameter of the central opening in the revolving disc (see figures 2 and 3), F, 3 mm.; the distance from the object-circle (from A to O,) to the anterior surface of the prism, 3075 mm.

A larger object-circle is not desirable, and if a greater distance between it and the prism is wished, say twenty feet, the deflecting power of the prism must be diminished. A longer space between these will secure a greater separation or lapping of the object-circles, which will enable the patient to see this effect more readily than when nearer to the object.

It is now desired to know the total refracting power of a given prism. To determine this the prism is mounted in the eye-piece, and the central opening exposed to a beam of sunlight, and the two round images of the opening received upon a white, flat surface, the latter placed at right angles to the beam of light, and say 1000 mm. from the anterior surface of the prism. The circumference of these two images is marked off on the white surface, and the distance between the inner edge of one circle and the outer edge of the other measured. This will give the deflecting power of the prism at 1000, which is 71.75 mm. in our prism. What will be the deflecting power of this prism at 3075 mm. from its front surface to the object-circle? This is found by simple proportion. Thus: 1000 : 71.75 : : 3075 : 220.-63125 mm. We construct an object-circle accurately round of 220.5 mm. diameter, in the front surface of the object-plate; and after carefully correcting our own eye, we find that the true and false circles touch at their inner edges. Since now we find the two methods verify each other, the instrument may be assumed to be correct, especially if, on revolving the prism, the inner edges of the object-circles touch at every point of the lower semi-circumference.

What is the deflection of this prism in degrees? This may be determined by the well-known proposition, that, in a right-angled triangle the square of the hypothenuse is equal to the sum of the square of the other sides. It must be remembered that the distance from the prism to object-circle is cosine, and from this, in part, we obtain the radius.

Figure 4 is necessary to illustrate. Let A C be the cosine, 1000 mm. in this case, or one side of the triangle, A B C, and C B, be the other side, 71.75 mm., deflection of the prism at 1000 mm. Describe the arc, E B F G. What is the radius of this arc, or A B the hypothenuse? By the proposition we have the formula $\overline{AC}^2 + \overline{BC}^2 = \overline{AB}^2$. Substituting $\overline{1000}^2 + \overline{71.75}^2 = \overline{AB}^2 = 1000000 + 514{,}0625 = \overline{AB}^2 = 1005148.0625 = \overline{AB}^2$. Extracting square root last quantity $AB = 1002.57072$ mm. The latter quantity being the radius, the natural sine = the deflection of prism divided by the radius, or $\frac{71.75}{1002.57+} = .071655$. This denotes a prism having a total deflecting power $4° = 6' 31.2''$.

To render the rays of light still more parallel, I have lately increased the distance of the object-circle from the prism to about twenty feet, or 6045 mm., and diminished the refracting power of the prism, which gives a smaller object-circle.

This prism refracts at 1000 mm. 25.5 mm., and at 6045 the refraction is 154.1+ mm., which is the diameter of the object-circle, and agrees with the size of the same circle found by experiment with the corrected eye. The total refraction of this prism is $= 0° 8' 43.8''$.

A few examples in the practical use of the instrument may be given:

A young man aged 17 years, on looking through the prism, states that the images are lapped when the index is horizontal. I know he is myopic, because these are lapped in that meridian, and now placing different concave glasses in the clip behind the eye-piece, it is found that a —37-inch glass causes the images to touch in the left eye. On revolving the prism the images separate, and this separation is greatest when the index is at 50° left, corresponding to 40° right axis of the prism. On placing a + 30-inch cylindrical glass, its axis is at 40° right side, the images just touch at that point. I now revolve the prism, leaving both glasses in the clip, and find that the images touch in all the semi-circumference. I place these glasses in a trial frame, the cylindric at an axis of 40° right, and he reads No. 15 Snellen at 15 feet.

In the right eye index horizontal (the defective meridian) the images are lapped; a —37-inch spherical glass brings them together. Turning the index to (left) 60°, the images are apart most at that meridian, and on placing a + 15-inch cylindric its axis at 30° right, the images touch, and now, on revolv-

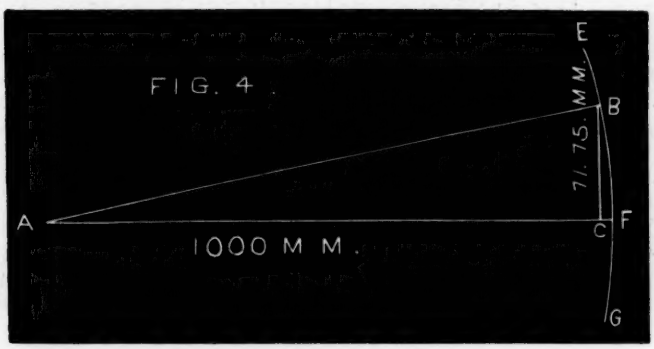


FIG. 4.

ing the prism, they touch at every point of the semi-circumference. I place these glasses in a trial frame, as above, the axis of the cylindric at 30° right, and he reads No. 15 Snellen at 15 feet. $V_2 = {}^{15}/_{15}$.

CASE 2. A boy æt. 16; index horizontal; sees images lapped; on trial, a concave 21-inch glass brings them together. On revolving the prism, index at 5° right, images are apart most; on placing + 49-inch cylindric, its axis at right angles to the index, or 85° left, the images touch, and on revolving the prism they touch in all the semi-circumference in the right eye, V R $= {}^{15}/_{15}$. In the left eye index horizontal, images lapped; a—21″ spherical glass brings them together. On revolving the prism, index at 5° left, they separate most at that point, and on placing a + 49-inch cylindric, its axis at 85° right, they touch at that degree, and in all the semi-circumference on revolving the prism. I place the above glasses in a trial-frame, and he reads No. 15 Snellen at 15 feet. His astigmatism and myopia are, therefore, corrected.

CASE 3. A gentleman, 54 years old, on looking with his right eye, finds the images apart, index horizontal. By trial, a + 37-inch spherical glass causes the images to touch. On revolving the prism, they touch in all the semi-circumference. I place + 37″ spherics in the trial-frame, and he reads with each eye Snellen ${}^{15}/_{15}$, and with both eyes the same. His hyperopia has been corrected.

CASE 4. A lady, æt. 20, reads unaided with left eye Snellen 200 at 15 feet, and in right, O, Snellen at 15 feet. On looking, she cannot with the right eye distinguish the outlines of the circles, but only a light, blurred appearance. I do not know if she is myopic or hyperopic, but suspect myopia, from the form of the eye. I apply a 30″ concave; she sees better, and finally with a spheric 2½-inch glass the images are distinctly seen to touch, and on revolving the prism they do so in all the semi-circumference. In the trial-frame, with this glass she reads Snellen ${}^{15}/_{50}$.

In the other eye, index horizontal, images blurred —weaker concaves improve the vision, finally—8¼ inch spheric causes the lapped images to touch. On revolving the prism, index to 15° left, the images are lapped (to the greatest extent) again, and on placing by trial a —9¼-inch cylindric, its axis at 75° right, they are brought together, and now they touch in all the semi-circumference. On placing this combination in the trial-frame she reads Snellen ${}^{15}/_{70}{}'$ & $V_2 = {}^{15}/_{50}{}'$.

CASE 5. A lady, æt. 25 years, on looking through the instrument with her left eye, finds the images most lapped the index at 5° right, but they touch at the other meridians. A — cylindric of 21 inches, its axis placed at right angles to the index, or at 85° left, causes the object circles to touch. On revolving the prism, the images touch in all the semi-circumference.

The other eye, detected in the same manner, requires a—15-inch cylindric, its axis at 85° right, and now the images touch in all the semi-circumference. She can now read with either eye and with both ${}^{15}/_{15}$ Snellen, and the simple astigmatism has been corrected.

CASE 6. A young man æt. 22 years, sees with his left eye the images most apart index at 30° right. A + eighteen and one-half inch cylindric, its axis at 60° left (at right angles to the index), causes the images to touch. On revolving the prism index to 30° right the images are most lapped, and a — thirty-seven inch cylindric, its axis at 60° left, causes them to touch. The images now touch in all the semi-circumference on revolving the prism. The other eye requires a + twenty-one inch cylindric, axis 75° right, and a — thirty-seven inch cylindric, axis 15° left. With either eye and both he reads S ${}^{15}/_{15}$, thus his crossed astigmatism has been corrected for each eye.

This instrument, excepting the prism, was made in this place. It need not be expensive, and any one familiar with the subject can set it up. Its description may seem intricate, but, when seen, its construction is quite simple.

All that the observer has to answer, in being tested, is, do the images touch, or are they apart, or do they lap? If apart this denotes hyperopia; if lapped, the patient is myopic. Even children can answer these questions satisfactorily. It is commendable, then, as the observer can at once comprehend his part in the examination.

It is also a great time-saver, a few moments enabling one to determine the glasses required, in the most exact manner.

The name selected for it is PRISOPTOMETER, from *prisma*, prism; *optikos*, optic; and *metron*, measure; denoting a method of estimating ametropia by means of a prism.

Finally, we could have demonstrated fully all the optical problems belonging to this subject, but do not consider it necessary, as these are found in standard works. We only have desired to present the instrument for consideration in a practical manner.

We have modified this instrument in various ways, but have decided this to be the most practical method of using a prism for measuring ametropia. Thus, we tried to use a + six inch glass in combination with the prism, to overcome the action of the ciliary muscle and enable the use of a short tube, to render the instrument more convenient, but this was not effectual in controlling that muscle. Again, we endeavored to use a telescope with the prism, but this would not answer, for the patient simply looked at the near image in the telescope, when the case demands that the object should be placed at quite a distance from the eye of the observer. Numerous other plans were adopted in the use of the prism, but all failed but this upon which we now rely.

It is the duty of the manufacturer to give the distance from the object circle A to the front surface of the prism at O, Fig. 3, for each instrument. The purchaser, in setting up this instrument, should hang up the object-plate *d*, Fig. 3, upon a wall securely, by the hooks *c c*, and place the eye-piece, attached to the tripod, at the distance A O given by the manufacturer. Looking through the aperture O at the object-circle A, Fig. 3, and the index being at 90°, on the *left* side, as at E, Fig. 2, the two images will touch, as at A A′, Fig. 3. Turning the index up to

0°, Fig. 2, the images will touch, and still revolving the index to 90°, on the *right* side, the images will be tangent, and if the images touch at *these three points* the position of the tripod is correct, and the foot-plates, *p p p*, Fig. 3, should be screwed to the floor securely and permanently. Thus the tripod can be removed from the plates, or placed in them when the instrument is in use, and the distance between the eye-piece and the object-plate is always the same when the instrument is in use, WHICH IS ABSOLUTELY ESSENTIAL. *The eye of the party setting up this instrument should be corrected, by test-types and glasses, else he will inflict his errors of refraction upon his patients.*

Messrs. Geo. Tiemann & Co., 67 Chatham street, New York City, are the manufacturers of the instrument.

Zanesville, O., Oct. 26, 1883.

SOME GENERAL FACTS CONCERNING INEBRIETY.

BY T. O. CROTHERS, M.D., SUPERINTENDENT WALNUT LODGE, HARTFORD, CONN.

A careful study of cases ot inebriety from any point of exact science will always lead to the same conclusion, that inebriety is always a positive physical affection, with a distinct ætiology and symptomatology.

The theory of half vice and half disease, to be remedied by moral means at first, then, when these fail, resort to physical and medical appliances, has no support from scientific study and the natural history of the cases.

When the history of many cases are studied and compared, the evidence is unmistakable that inebriety is a form of insanity, distinct and prominent, requiring special study, and special means and methods of treatment. Also, that, ætiologically, they divide into two groups or classes in which are included all cases.

The first group are those cases in which inebriety is an expression of a neurotic defect of the brain centers, frequently inherited and developed through certain exciting causes, of which alcohol is the most prominent.

Inebriety is always associated and marked in this group with physical signs and hints that suggest an imperfect development; great weakness or convulsions during childhood; retarded mental growth, approaching idiocy, or extraordinary precocity, with brain growth and development far in advance of their age.

The crisis of puberty develops perversions and changes that determine all the after life in such cases.

From this time emotional exacerbations, nutrient disturbances and perverted ambitions, which merge quickly into inebriety from the slightest causes.

Obscure states of nerve exhaustion, called properly, "a decline," are most quickly relieved by some form of alcohol, which sooner or later ends in inebriety.

Often alcoholic excess or intoxication follows the first use of spirits, then a long period will follow in which no spirits are used, or, if any, in great moderation.

But an inebriate soil has been prepared, and only awaits a favoring germ cause to spring into activity. During this period of incubation, in which no alcohol is used, a high degree of mental activity is frequently prominent. He will exhibit great strength, coupled with eccentricity, and a changeable, erratic line of conduct.

If he is a public man his conduct will excite great admiration and condemnation. If in business circles, he will be an extremist in work and judgment.

Farther on, he may be very passionate and irritable, and will not bear opposition. Often these men are the wild advocates of new schemes of every description.

A large number of the foremost temperance reformers have been of this class; always on the verge of inebriety, with every symptom and indication present, except the use of spirits.

The religious ranks have numerous types of this class, in which some slight variation or change, and the pronounced inebriate appears.

They are neurotics from infancy, and varied conditions of brain and nerve instability appear along the course of life.

The organism is not fitted to harmonize with the varied surroundings, or to bear the strains incident to constant change.

Neurasthenic states, psychical neuralgias, marked by depressions, and complex symptoms of every kind, that are as intense as they are transient, all crave some relief from outside sources, and find in alcohol a narcotic of the most seductive character.

Thus, under the mask of relief, alcohol kindles and develops a disease that has a most favorable soil for its growth.

Hence it appears that inebriety is an expression of nerve degeneration and exhaustion, which has begun long before alcohol was used, and this drug builds up diseased tendencies and pathological changes that ever after crave its narcotic effect.

In the second group, inebriety is an expression of certain states of ill health, and failure of brain and nervous system, growing out of special physical conditions and surroundings.

This is seen in cases of inebriety that have sprung up in bad sanitary surroundings, where bad food, overwork and underwork, and want of proper rest, have brought on conditions of the body for which alcohol was demanded, and produced relief.

The two extremes of society furnish the most numerous examples.

The very poor, who from their sufferings and necessities develop a low state of health and impaired brain force; and the very wealthy, who from want of healthy activity and hyper-nutrition, are also equally impaired in vigor and health; are grounds from which a large number of inebriates are constantly recruited.

Where inebriety does not appear in the very wealthy class, it follows in their children with more or less certainty, and can be traced to a line of distinct physical causes.

Inebriety frequently appears in a middle class ot hard-working, temperate men, and has in some cases an obscure origin and progress.

In many cases, active, temperate men will suffer from some protracted sickness, and after recovery begin to use spirits, either to excess at once or after a short period of moderate drinking. Thoughtless people will find that alcohol has been used as a medicine, and conclude that this was the only cause, and thus condemn the physician, when, in fact, inebriety came from some injury to the brain centers following the illness.

The changes of vigor and health following any protracted disease, and the entailments that develop other troubles, are the common observation of the profession.

The same will be found true in many cases of inebriety which are literally the results of pathological changes that have begun long before.

Traumatism is another starting point of inebriety in this class. A direct injury to the brain from a fall or blow, or a severe wound, or exhausting hæmorrhage, is in many cases the beginning of inebriety, which may begin with a period of moderate drinking, or with impulsive and excessive use of spirits at once.

Psychical traumatism, or injury from mental shock of any kind, is another common cause in persons who were previously temperate and healthy.

Here inebriety is a hint of some injury to the nerve centers, and unmistakable sign of pathological change.

These are the cases whose obscurity suggests a spiritual origin, to all who are anxious for an explanation of all the phenomena of nature.

Such cases are invariably interpreted as springing from the sudden growth of a sinful nature.

A great moral lapse of character and giving way to evil of the heart.

In the first group vice and sin was rampant from the start, in the latter it simply triumphed at last after a long struggle.

In the first group are those whose general history, both physiologically and psychologically, borders more or less closely on that shadowy land of disease, insanity and crime.

In the second group inebriety is acquired, and the outgrowth of physical states and injuries.

The theory that in all cases alcohol is the only cause, is unsupported by facts from a study of cases.

The methods of treatment where alcohol alone is removed, furnish strong evidence that this is only one of many causes, in the many failures that follow.

When the history and symptoms of a number of cases are accurately observed and compared, they will be found to follow a certain uniform line of progress.

Beginning at a certain point, the same stages, marked by the same symptoms, follow each other with a regularity that points to the reign of law, and causes that are uniform in their action.

In most cases two periods appear to be prominent; one beginning somewhere in the past, sometimes traceable, but generally obscure, marked by certain signs of mental and physical debility, which increase along a regular line, that can be often defined and predicted.

The second period dates from the first toxic action of alcohol, intoxication, or excessive use, and ending in death. This is also marked by distinct stages, that are uniform and clear. The progress of the case from this time is within the observation and range of every general observer.

It may not always be uniform; halts and variations in the order of events may appear, but the same general line is preserved.

All study of these cases indicates the possibility of predicting the approach of inebriety, and anticipating its march and progress at every step, with the same certainty that the movements of the heavenly bodies are known.

What we want, is a knowledge of the forces and causes, and the influences on certain physical organizations; then the problem will be clear.

Another conclusion still more startling comes from a general study of these cases. It is that inebriates are the results of physical causes and conditions; that they are grown and manufactured, as much so as cotton and wool, and the machines to work them into fabrics, the difference being only in the process of manufacturing, whose complexity is beyond our present knowledge to follow out.

In outline we can trace an intimate relation between inebriety and great social revolutions, wars, and disasters which affect the interests of large sections of country.

We can see inebriety coming from the neglect of great physical laws; we can mark its footsteps as a tide of disease, ebbing and flowing, following some unknown germ cause, and we know that the same eternal order of cause and effect reigns here as elsewhere.

As medical men, it is our duty to find out these causes and the laws which govern them.

The impulse to use alcohol is not an accident or evil impulse to do wrong, which might be checked with ordinary prudence and self-control. It is the outburst of some diseased tendency, which seeks relief, and grows into great proportions by the very means which it demands.

Let the conscientious observer start from any point of inquiry and seek facts alone, and he will arrive as the same conclusion, that inebriety is a physical disease, and as he goes on further in his investigations, the causes and their prevention will come out distinctly and with startling significance.

He has touched the shores of an almost unknown continent, about which to-day there are written those sands of volumes, and hundreds of papers, whose descriptions of this country are worthless, and whose theories are but fags and superstitions of the infancy of the subject.

Inebriety can not be reasoned out, it must be seen and studied as a new country, above all theory and speculation.

The problem is a serious one, and its solution determines the interests of vast numbers of persons. Personal, social and political interests are involved, the influence of which are becoming more and more important every day.

Inebriety is increasing far more rapidly than the increase of population.

Penal methods of punishment for restraint are everywhere recognized to be failures; and worse than all, increasing and making the victims more incurable. Short terms of imprisonment and fines for the purpose of checking inebriety, are literally building up and educating a chronic class, that always entails heavy burdens on the community, and is a source of peril to law and order.

The methods by appeals to the emotional faculties, to sign the pledge and become converted, must of necessity fail, as they do not recognize the physical condition of the inebriate.

The time has come for medical men to teach the public what inebriety is, and is not, and not the victims of this malady and the teaching of moralists whose shifting dogmatism is unworthy of notice.

The problem is a medical one, and can only be solved by an appeal to the facts gathered from many sources by accurate observers.

Every physician in the country can study inebriety in his own circle; he can group the facts he may discover, and deduce some laws which govern them. In this way he can become a pioneer, and thus help to solve a problem against which all theory and speculation will beat in vain.

The time has come to put on one side the theories of the hour, and demand the facts and their meaning above all theological and popular notions of the day.

If inebriety is a physical disease, then we have it in our power to reach and prevent it by the use of physical means along the line of causes.

If inebriety is the outcome of physical conditions and surroundings, then a knowledge of these will enable us to apply preventive medicines and means that will reach out and prevent the disorder, and restore the victim.

Here is a field where the best trained medical men of the country will find vast regions of unknown facts, and where each may be a discoverer untroubled by rivalry or competition with others.

SOME MEMORIAL REMARKS ON THE LATE DR. J. W. PRITCHETT.

GENTLEMEN OF "THE MCDOWELL MEDICAL SOCIETY:"

Fortunately for the present incumbent of that chair, the custom requiring an address from the President has been abolished. Yet it occurred to me that a few remarks upon the life work of our lamented Fellow and former President, Dr. Jno. W. Pritchett, would not be inappropriate on the occasion of its first meeting after his death.

Consequently I have jotted down during a few moments snatched from the cares of domestic affliction, and the worry of business, some notes of his life and death.

Dr. Pritchett was born in Hopkins county, Ky., near Madisonville, its capital, on the 6th of June, 1839, and died at his residence in Madisonville, July the 21st, 1883, being at the time of his death 44 years of age. Though thus early called from his labors, he had accomplished much that deserves commendation and honor, especially when we recognize the circumstances that surrounded his youth and embarrassed his early efforts. He had no opportunity of an early education, but was compelled to labor on his father's farm until he was eighteen years of age; when, inspired as it were by an irresistible desire for knowledge, and a larger field of usefulness, he determined to obtain an education, and prepare himself for a professional life, and chose medicine as affording greater opportunities for doing good. He accordingly went to Harrodsburg, Ky., one of the early fields of the professional labors of our distinguished Henry Miller, who was his model as a man and physician. There he attended a literary course. From Harrodsburg he went to Ann Arbor, Michigan, and attended its medical college for one term, doing some practice as an undergraduate between terms, and finally graduated at "Jefferson Medical College," Philadelphia, in March, 1864.

Immediately on his return from Philadelphia he resumed his practice in his native town, where, without intermission or rest, he continued to labor in the profession of his choice, up to the day on which his diseases, by their slow but sure inroads upon a constitution not naturally robust, but elastic and enduring, compelled him to give up work and an active life for a lingering confinement to a sick room—the greatest trial to such a spirit. He was confined to his bed nearly seven months by hepatic trouble and bronchitis, which latter, perhaps, terminated in phthisis pulmonalis. He suffered but little pain, but was the subject of constant cough, accompanied by fever. Though annoyed so long, one who nursed him much during his long illness, writes: "His patience and resignation have never been excelled, for in these he was perfect." Without a murmur he waited for the end. He was always conscientious in his attentions to all who placed themselves under his care, or to those who were committed to his professional guidance, whether rich or poor. He rarely ever permitted pleasure to interfere with his duties and obligations to his patients.

He continued to work long after he was physically unfit for exertion of any kind, and often would deprive himself of much needed rest to visit a patient whom he found much less disabled by disease than himself. From the beginning of his professional life he was very successful, both as a general practitioner and surgeon, and secured from the first a very extensive practice—but, as I am informed, not a very lucrative one, from the fact that he never paused to consider the financial condition of his patrons, but went when and where he was called, scarcely thinking of compensation or reward, except the consciousness of having done his duty by his efforts to relieve human suffering.

Dr. Pritchett could have consistantly adopted as the embodiment of his professional life the sentence attributed to the celebrated Borhaave, "The poor are my best patients for God is their paymaster," as he truly won the title of the "poor man's doctor," which to the eye of God and the true philanthropist, is a proud and noble title. As to his deserving it, no better proof is necessary, than the numbers who attended him daily during his long illness, and the

long procession that followed his remains to their narrow abode; and really there *can* be no better evidence of a useful and unselfish life; nor could a more eloquent eulogy be pronounced, than this demonstration of the high and grateful esteem in which he was held by those whom he had so faithfully served, and so often relieved by his skill and watchful care, those to whom he had never failed to minister in their hour of sore affliction and need. To them he was truly "the beloved plysician."

It was my good fortune to become intimately acquainted with Dr. Pritchett for several years before his death, and to some extent possess his confidence, often meeting him in attendance on the "American Medical Association"—The Kentucky Medical Society, and on this Society—of all three he was a member, and also of the Tri-State Society of Indiana, Illinois and Kentucky. Of this Society he was an ex-president, and consequently to you gentlemen who knew him so well, no eulogy of his life and character, or tribute to his memory is necessary, for I am convinced that no feeble words of mine could add to the already high position he occupies in your hearts, as an earnest and sincere physician, a modest and unassuming member of not only this Society, but of your good and truly great profession. He had profound confidence in medicine to prevent and cure disease. His courtesy and love for the members of his profession was constantly exemplified by his actions. He was always ready to uphold and encourage every worthy member of the profession by word and deed.

Though an enthusiastic advocate of medical organzations—unlike some, it was not with the hope of place or position in them—but for the aid, as he expressed it, which such organized bodies of medical men rendered medical progress, and the ethical spirit that such organizations promulgated, enforced, and kept fresh in the minds of their members, was the life of medicine.

Would to God this was always the case, and that every one who bears the title of M.D. would become not only members, but attending and active members of well organized societies. Dr. Pritchett's high sense of honor towards his professional brethren, and his strict adherence to every provision of the Code of Ethics—as far as your memorialist's observation extended—was especially commendable. His domestic relations, from the same standpoint, were characterized by pure affection. He was genial and affectionate in the domestic circle, where his loss is most deeply and keenly felt. Ever to the writer, his social qualities were of the most cordial character, his hospitality profuse, his friendship true, and characterized by sincerity and durability. One quotation made by his faithful nurse and devoted wife, in a letter to me, speaks a volume of the loss, grief and sorrow his death occasioned in the heart of her who deserves our sympathy, as the life-companion of our professional associate and friend.

In the letter giving date of his birth and death, etc., she says: "I can only add, how I grieve 'for the touch of a vanished hand, and the sound of a voice that is still.'"

Dr. Pritchett gave promise of much more than a local distinction as a surgeon, which he had already deservedly earned in his community, as the result of several successful operations of a formidable character; but, like so many of our promising workers in the field of medicine and surgery, he was prematurely cut down by that inexorable man with the scythe, yet in the prime of his usefulness, and just as he had fully entered the inner hall of the practical temple of medicine, with its walls adorned, as they must be to insure success, by the mind-pictures of long years of experience, and accurate observation of disease in all its protean forms; or, in other words, a memory well stored with pictures of his past experience, the only sure guide for the future, for theories are deceptive. He was evidently a "self-made man," which is always the more useful and better class of men, when they make themselves right.

He idolized his profession as the noblest, and reverenced the great among its members as the greatest among men; but if he had a special idol on earth, and one which he considered as the legitimate offspring of professional love and scientific zeal, that idol was "The McDowell Medical Society."

Consequently, in closing this brief, imperfect and unworthy tribute to the memory of one of its most faithful members and earnest workers to maintain its usefulness, and promote its reputation for scientific and practical work, which it has so deservedly earned by the character of its papers and the usual ability with which they are discussed at each semi-annual meeting, permit me to suggest the appointment of a committee to draft suitable resolutions of respect for *its* devoted son and *our* brother, and sympathy for his bereaved wife and five fatherless children.

MEDICAL PROGRESS.

MEDICINE.

ON PYLORIC INCONTINENCE.—Under this title Ebstein, in the *Press Medicale Belge* (Archives Medicales Belges), considers the difficulties in making a proper diagnosis of affections of the stomach, especially in locating the seat of the disease at either the pyloric or cardiac orifice of the stomach. Among the appreciable affections of the pylorus is the stenosis or contraction of the orifice, the symptoms of which, according to Abercromie, consist of periodical vomiting after meals, and a persistent, painful sensibility in the gastric region. There are also cases where the closure of the pylorus is incomplete, forming a true insufficiency or pyloric incontinence.

In the normal condition the pylorus closes completely, separating the stomach from the duodenum. The anatomical arrangement of the tranverse and longitudinal fibers is a proof of this. Glisson, however, considers that the cardiac orifice alone contracts. Henle believes that it (the cardiac orifice) closes as energetically as the pylorus. According to Ebstein, during digestion the pylorus, which has been closed, becomes fatigued, and relaxing, allows the alimentary fluids to pass out by degrees, to be followed by the solids. In other words, it loses gradual-

ly its contractility, under the influence of the repeated stimulus of the contents of the stomach.

Ebstein attempts to prove the occlusion of the pylorous by distending the stomach with carbonic acid, introduced as tartaric acid and bicarbonate of soda. He introduces 5 or 6 grammes of a mixture composed of 10 parts of bicarbonate of soda to 9 parts of tartaric acid, which results in the formation of 1,500 to 1,800 cubic centimeters of carbonic acid. If the pylorus is normal, the resulting distension, as shown with dogs, does not extend to the intestine; and he considers that this mode of procedure should prove of marked value in the diagnosis of pyloric incontinence. It also projects the walls of the stomach against the abdominal parietes, and permits of a mapping out, through percussion, of the contours of the organ itself. If the pylorus is sufficient and closed in the normal manner, percussion produces no modification of sound in other parts of the intestinal canal. On the contrary, if the pylorus is insufficient, we have a tumefaction of parts of the intestine in connection with the gastric distension, like acute tympanitis. Ebstein cites two cases where pyloric incontinence was diagnosticated in this manner during life, and the diagnosis confirmed by post-mortem evidences.

The established fact of pyloric incontinence does not, however, give any assistance in determining the nature of the disease which is present. Purely nervous causes may produce it, but for the greater part it is due to ulcerative destruction or to infiltrations, which interfere with the proper functions of the sphincter.

Local Temperature in Diseases of the Abdominal Viscera.—According to Prof. Peter, in *Le Praticien*, (Archiv. Med. Belges) the temperature in these affections is elevated in direct proportion to the intensity of the inflammation. In the absence of all disease, in the normal condition, the temperature of the abdominal parietes is much below that of the axilla, ranging from 95°.6 to 95°.9; but under the influence of a phlegmasia or of an irritation it may equal or exceed the axillary temperature. This fact may serve, for example, as a means of distinguishing between simple gastralgia and pains in the stomach which are due to some form of gastritis.

In a young girl suffering from ulcer of the stomach, while the axillary temperature varied between 98°.3 and 98°.6, the epigastric temperature was, in the intervals of pain and vomiting, between 98°.6 and 99°.5, and when the hæmorrhages occurred it reached 101°.3.

In a man affected with chronic alcoholic gastritis, the temperature of the epigastric region rose from its normal 95°.9 to 98°.3, while the axillary temperature was 98°.6.

In a patient affected with chronic gastritis, caused by insufficient alimentation, the epigastric temperature reached 98°.3, the axillary temperature being 98°.6. This elevation of the temperature led to a diagnosis of gastritis with fluxion or congestion, and eliminated the purely nervous gastralgia.

In a patient attacked with hepatic colic, at each crisis the temperature in the right hypochondriac region exceeded that in the left to the extent of 1°.8, 2°.7, and even 30.4.

In tubercular peritonitis, the temperature rises ordinarily 1°.8 to 2°.7. A case of tuberculosis, which suffered from abdominal distension, pains, etc., not having an abdominal temperature above 95° 9, enabled M. Peter to eliminate tuberculous peritonitis, and to diagnosticate a pseudo-hysteria, a grouping of nervous symptoms which are not rare in phthisical cases.

Severe Hiccough.—Dr. Ruhdorfer, in the *Allgemeine Wiener Medizin Zeitung*, reports a severe case of the above, lasting for three months, and which morphia, given hypodermically, could only check for a few hours or days. It resisted all the usual remedies, such as quinine, alone and with extract of belladonna, tincture of castoreum, or tincture of valerian, in water or with aromatics, mustard poultices over the stomach, dry cupping down the spinal column, chloroform, ether, zinc, bismuth, numerous emetics, and purgatives. The patient dragged on for three months under various remedies, morphia being administered whenever a single attack lasted beyond eight hours. At last the attack became overpowering, and the hiccough was so loud that the patient could be heard outside the house, through two doors. She sat up in bed, supported by her parents; there were dyspnœa and cyanosis; the head was jerked in all directions, the pulse was small and frequent; the neck was distended. Remembering a case in the *Revue Medico-Chirurgicale*, Dr. Ruhdorfer injected a solution of pilocarpine hydrochlorate (3 centigrammes in a gramme of water). The hiccough was at once cured, as if by magic, and has never returned since. —*British Medical Journal.*

Downward Displacement of the Transverse Colon. — Dr. Charles Hermon Thomas, in *Illustrated Medicine and Surgery*, records three cases of this curious affection. In the first, a man 80 years of age, the most dependent part of the gut was found midway between the umbilicus and the pubic symphysis; in the second, a woman 54 years of age, it was deeply impacted in the pelvis; and in the third, a man 30 years of age it reached the level of the umbilicus. In the first case there was tumor and profuse diarrhœa. In the second case there was pain, referred chiefly to the region of the liver, existing for five years, obstinate constipation with indications of obstruction, and two solid tumors occurring at intervals, which proved to be the descending and ascending limbs of the displaced transverse colon. In the third case there was pain, and tympanitic resonance on percussion. No adhesions of the displaced parts were found in any of the cases cited.

Nephritis Produced by the Compression of the Ureters in the Course of Cancer of the Uterus, with Consecutive Hypertrophy of the Heart.—M. G. Artland (*Revue de Médecine*) gives the details of six cases observed by himself and M. Straus, to illustrate the discussion of this subject. The con-

clusions reached by him are, in effect: That in the course of cancer of the uterus, there may develop, as the result of compression of the ureter, certain lesions of the kidney, differing in their character according to the degree and duration of the compression. When the compression has been slight, the kidney remains normal in size or is slightly increased in volume, the histological lesions consisting of a nuclear infiltration about the uriniferous tubules and vessels, a hypertrophy of the glomeruli, and a dilatation of the convoluted tubes, the epithelium of which has undergone a fatty-granular degeneration. The collecting tubes have remained very nearly normal, and their epithelium does not seem to be altered.

When the compression has been so prolonged that the ureter and pelvis have become markedly distended, the kidney atrophies, and the degree of atrophy is in direct relation to this dilatation of the ureter and pelvis. The histological lesion consists in the change to a fibrous condition of the previous nuclear infiltration, in the obliteration of the collecting tubes, the epithelium of which has undergone the embryonic retrogression. The glomeruli are either fibrous or cystic. The convoluted tubes present the same change in their epithelium as before mentioned.

These lesions of the kidney are similar to those which are produced in ligature of the ureter in animals. They differ from the latter in the fact that they constitute a diffuse nephritis, rapid in its course, in the development of which the inflammatory element takes the greater part; whilst the mechanical element is predominant in the evolution of the kidney lesions resulting from the aseptic ligature of the ureter.

These renal lesions caused by the compression of the ureter in the course of cancer of the uterus, frequently produce an hypertrophy of the heart, which affects exclusively the left ventricle, and which is rarely, if ever, accompanied by interstitial myocarditis

TOXICOLOGY AND MEDICAL JURISPRUDENCE.

ON PTOMAINES, OR CADAVERIC ALKALOIDS.—There has recently arisen in patholgical chemistry a class of substances known as ptomaines, the properties of which are becoming more clearly defined, but which are very little known to those who are not directly workers in that branch of medical science. A writer on this subject in the *Lancet*, R. N. Wolfenden, M.B., who is the lecturer on physiology in the Charing Cross Hospital Medical School, calls our attention to this, and to the fact that the lawyers have already found them out, and made use of some of their peculiarities in arguments for the defense in a recent trial for murder.

The term ptomaine is a misnomer. It was first applied by Selmi to these bodies, to indicate that they were of cadaveric origin; but investigations are rendering it more and more probable that alkaloids of a poisonous nature occur in certain pathological conditions, and possibly also normally as a product of change of living tissue. Selmi supposed them to be products of putrefaction of organized nitrogenous material. They are variable in their nature according to the length of time after death, and though not present within a few hours after death in any appreciable quantity, they slowly develop with advancing decomposition. They are often amorphous in form and alkaline in reaction, for the most part volatile and easily alterable, forming crystalline salts with acids as a rule. The addition of acids to them usually changes them, with the production of pleasant odors like orange flower, musk, etc. Allowed to oxidize by contact with atmospheric air, they emit disagreeable cadaveric or urinous odors.

Some of these ptomaines are not poisonous, but most possess strongly toxic characters, and cause profound symptoms when injected under the skin, such as paralysis, more or less complete, of hinder extremities, dilatation of pupils, convulsions, muscular flaccidity, slowing or acceleration of the heart, loss of cutaneous sensibility and of muscular contractility, possessing many of the characteristic physiological actions of muscarin or atropin. They answer to nearly the same reactions as the vegetal alkaloids, and all have a strongly reducing action on potash ferridcyanide. They yield color reactions with sulphuric acid (red), iodic acid and sulphuric acid (violet), nitric acid (yellow), etc. These ptomaines are met with under the following conditions:

1. As a constituent of normal tissues or juices. In this case they are products of tissue metamorphosis. *Saliva* evaporated to dryness, extracted with boiling water and filtered, gives a toxic substance which converts ferridcyanide of potash, along with one or two drops of ferrichloride, into Prussian blue. Injected into the thigh of a frog, it kills the animal, and differs from snake poison only in the greater intensity of the latter. Normal *urine* gave Gautier a fixed oxidizable alkaloid, which forms a crystalline chloride, and also a crystalline double salt with platinic and gold chloride. This alkaloid is very poisonous, killing quickly with systolic standstill of the heart, stupor, and paralysis.

2. In certain pathological conditions. In the urine of patients suffering from progressive paralysis there are two volatile bases, the one like nicotin, the other like coniin. In the urine voided during a case of interstitial pneumonia were two alkaloidal bases, one having the odor of stinking fish, the other of ammonia. Two similar bases were found in the urine of patients with abdominal typhus. In tetanus a base like coniin was discovered in the urine. In the urine of "miliary fever" an alkaloidal base having the odor of stinking fish has been observed.

3. As cadaveric or artificial. There can be no further doubt that these bodies are largely produced in the process of decomposition of nitrogenous or proteid tissues. There are many varieties of them and they vary much in their nature, according as the length of time after death is long or short. Stinking fish, bad meat, etc., all contain poisonous principles which can be extracted after the manner of ptomaines. The gastro-intestinal irritation and profound toxic symptoms produced by the ingestion of bad food are probably at the bottom processes of alkaloidal poisoning. By decomposition of neurin and albumen toxic bodies may be obtained much resembling mus-

carin. Both from freshly prepared peptone made by the action of gastric juice on pure fibrin, and from stinking peptone by boiling with caustic soda, evaporating, extracting and purifying, toxic alkaloids can be obtained which kill frogs and rabbits in a few minutes. Putrefying casein, brain substance, liver and muscle also yield these products. Some of these ptomaines are poisonous, some non-poisonous; and it is common to find a poisonous and a non-poisonous variety linked together. No chemical test has as yet been devised that is at all crucial, and the general reactions, taken along with their physiological peculiarities alone, can be taken as evidence of the presence of a ptomaine.

The ptomaines, so far described, are:—1. Ptomaines like atropin and hyoscyanium crystalline, and which dilate the pupil and accelerate the heart. They are obtained from putrescent albuminous fluids. 2. An alkaloid from decomposing yeast, called sepsin, which resembles strychnia. 3. An alkaloid resembling morphia in its tests, but not in its physiological properties. 4. One agreeing with delphinin. 5. One resembling strychnia, but not causing tetanus. 6. Alkaloids like muscarin. 7. Alkaloids like coniin. 8. Alkaloids resembling parvolin and hydrocollidin. To sum up the manner of production of these bodies:

1. There are developed in the body, post-mortem, poisons of an alkaloidal character, and which can be obtained also by decomposition of albumen, peptone, casein, muscle, brain, etc. Moreover, they seem to be present in some normal secretions (saliva and urine.)

2. These cadaveric alkaloids may be mistaken, post-mortem, for vegetable poisons administered with evil intent, but if the body be examined within from twenty-four to forty-eight hours after death, any alkaloid there found would be strong presumptive evidence of poison, and not ptomaine. After a couple of days it may be a matter of doubt.

3. There is no satisfactory test surely indicating the presence of a ptomaine. Physiological characters must be taken in conjunction with chemical tests.

4. Probably the production of ptomaines within the living body may be the pathological cause of many obscure conditions, especially those following on poisoning by bad food, such as stale fish, etc.

Tears of Blood.—M. Damalix has published in the *Archives d' Ophthalmologie* an interesting article on this rare phenomenon. A young girl, in the service of M. Panas, affected with non-convulsive hysteria, gave an account of being often affected with a discharge of blood, which soiled the handkerchief used in wiping her eyes. This discharge returned nightly during a specified time. Examination of the eyes showed that they were intact, the only noticeable affection being a marked blepharospasm, with photophobia and facial neuralgia.

There are a number of similar remarkable cases, the record of which leaves no question as to the possibility of such a hæmorrhage; in one case of Hasner's, and in another of M. Brun's, the observers saw the eye fill with liquid blood as it fills with tears, without the possibility of fraud. In the latter case, the microscope showed that the blood was very nearly normal.

As to diagnosis, it must be remarked that one would not describe as tears of blood the various hæmorrhages which are dependent upon a lesion of the orbit or of the mucous membrane. It might be that the little polypoid vegetations that develop in the conjunctival cul-de-sacs would escape attention, and cause a discharge of blood simulating this condition. But the tears of blood are absolutely independent of any ocular alteration, and their evolution is neither fixed nor regular. There seems to be no cause for their effusion. Without effort or pain these patients weep blood. The eyes become moist, the tears fall upon the cheeks, and it is when the patient wipes the face that the blood is first noticed. At other times there are certain premonitory symptoms, such as frontal pain, brow pain, or pain at the root of the nose; or perhaps a tickling or pricking sensation, with a feeling of warmth to the eye-lids; then, as the discharge occurs, the disagreeable sensations pass off. The discharge varies in quantity from a few drops to a liqueur-glass full, only lasting a few minutes. These phenomena are essentially intermittent, sometimes regular, but nearly always transitory and coincident with the different hæmorrhages of the skin and mucous membrane.

Considered ætiologically, the only fact which can be determined from analyzing these observations is that these tears of blood constitute a passing anomaly in individuals that are anæmic and inclined to hæmophilia, and that they can act as supplemental to the menstrual flow, but that they occur especially in the hysterical women.—*Revue Medicale.*

On the Possibility of Making a Cadaver Disappear Entirely by the Use of Ordinary Sulphuric Acid.—A. P. Reynard, Comptes Rendus de la Societe de Biologie) tells us that in consequence of the attempts made by Prof. Girard to totally destroy the bodies of sheep affected by charbon by placing them in their weight of commercial sulphuric acid, and thus destroy the virus that Pasteur declares cannot be destroyed by burial; he concluded that here was a means which might be employed to destroy the evidence of crimes committed, and made certain experiments to see how far a human body could be so disposed of.

This method could not very well be used in the case of adults, as it would require too much acid and vessels of too large size—but in the case of abortion or infanticide, unfortunately, nothing is easier than to destroy all traces of the crime by means of sulphuric acid. He placed the body of a new born child weighing 3 kilos, in a suitable vessel containing 4 liters of sulphuric acid. Thirty hours later, without the giving off of heat or odor, the cadaver had disappeared. The best means of disposing of the remaining acid is that which would most readily occur to the mind of the criminal, that is, to throw it into the drainage of the house—the pipes being made of pottery are not affected, the acid encounters the carbonate of ammonia from the urines, etc., sulphate of ammonia and carbonic acid is the result, and all trace, not only of the crime itself, but also of the means used to conceal it, is obliterated.

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THE EDITOR of this JOURNAL would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information, should be accompanied by the writer's full name and address, although not necessarily to be published. All communications in regard to editorial work should be addressed to the Editor.

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ANNUS MEDICUS, 1883.—It is withal a goodly custom which impels us at the beginning of each successive year to inquire into the year's endeavors, seek to discern its lessons, and thereby more advisedly enter upon the untried tasks and cumulative duties which are just ahead. Time and progress solve the most difficult problems. While some great genius may suddenly illuminate the scientific world, as instanced by Galileo and Newton, in the physical sciences, and our own Sims in surgical science, yet after all it is the steady accumulation of knowledge year by year which accomplishes the great achievements of scientific investigation.

In all departments of medical science the past year has been one of intense activity. Never before in the history of our profession have there been so many able investigators engaged in advancing the physical sciences, among which medicine stands preëminent. Human anatomy is regarded an exhausted science, and in so far as it is descriptive, justly so. Yet our esteemed contemporary, the *Annals of Anatomy and Surgery*, has given the profession some valuable papers in anatomy, and enters the new year with improved facilities for cultivating the sciences to which it is devoted. The past month witnessed the appearance of the last fasciculus of Prof. Harrison Allen's splendid treatise upon the human anatomy, of which a distinguished teacher of that department of science says: "I know of no similar work in any language which, either in text or illustration, is so well adapted to the wants of the medical student and practitioner." Thus it will be seen that anatomy continues to receive that attention from persistent and advanced investigators which it so eminently deserves, and which in time will materially improve existing knowledge. In physiology the greatest advances are evident in connection with researches upon the nervous system. We doubt not the forthcoming work of Professor John C. Dalton on the Topographical Anatomy of the Brain, will embody the results of mature and painstaking investigation in a field long cultivated by this distinguished author.

In general and special pathology, many valuable additions have been made to our knowledge. More than a year ago a strong impetus was given to the investigation of germinal pathology, by Koch's discovery and demonstration of the bacillus of tubercle. As usual with the advent of innovations, more was claimed by enthusiasts as the result of these investigations than is warranted. The professional mind has now realized that in this discovery more is indicated in the way of possibilities, than as absolutely determined in regard to the nature, progress, and communication of phthisis. In diagnosis, prognosis, and prophylaxis, Koch's investigations are destined in time to render most important service. Not the least agreeable to contemplate of benefits, is the encouragement given to that industrious and ingenious class of workers, headed by Virchow, who have done so much of late years to place practical medicine among the exact sciences. Among the notable events of the year, in this connection, is the work of the cholera commissions in Egypt, headed by Koch and others, the results of whose labors are not yet fully known. In practical therapeutics, the past year has witnessed a popularization of the physiological, in contradistinction to the empirical method, together with a wholesome appreciation of facts and a judicious examination of results. To our national pride it cannot but be gratifying, to realize that the two greatest works on therapeutics extant are from the hands of American authors, the preëminent value of which is attested by rapidly succeeding editions, and almost universal adoption as text-books, both at home and abroad.

The past year has witnessed the steady progress of surgical opinion towards a realization of the fact that the value of antiseptic methods consists for the most part in cleanliness and drainage, and little, if anything, beyond. In abdominal surgery, the most brilliant results have been achieved, and conditions formerly regarded incurable are now relieved by the bold use of the knife. In the various departments of general surgery, many and permanent additions to

knowledge have been made which time will not permit us to enumerate.

In obstetric practice, the greatest advance of recent times springs from the growing opinion that puerperal fever is not, as heretofore regarded, the result of a specific germ, but that it is identical in its nature with surgical pyæmia and septicæmia. The discussion of this subject by leading investigators in this department of medical science during the coming year cannot but be of great benefit to obstetric practice.

The advance of medical thought in America during the past twelve months has been more marked in no department than in the prolific field of sanitary science. In all matters appertaining to State medicine there is a degree of activity which has already accomplished much, and which is growing in efficiency and practical importance. That in all branches of preventive medicine we are making steady and substantial progress is evident to the most casual observer. One of the most welcome features of progress is the growing interest in sanitary matters on the part of the intelligent laity, and the increasing aid in the States to Boards of Health. There are still many needed reforms and improvements which we may confidently expect the near future to supply.

A consideration of the great activity in all the branches of medical science and practice brings to the mind of the appreciative reader at least one important suggestion. Never before was there a time when the duty was so imperatively enjoined upon the practitioner to study the development of recent investigations. To discharge the duties of the hour, the physician must be informed upon those advances which increase the extent and exactness of his knowledge, and extend the scope of his armamentarium. His greatest aid in all that appertains to progress and improvement is the medical journal which visits him from week to week.

In conclusion, we wish for all our readers a Happy New Year. In this trite form the compliments of the season are exchanged, but from one physician to another it means a great deal. No calling in life is so sublimely epic as that of the physician. His ministrations bring him daily in contact with scenes of anxiety and sorrow. His triumphs bring joy to men, women and children, and often he shares the common orrow. His happiness is so interwoven with that of his patients that in wishing him a Happy New Year, we bespeak the health and happiness of those who come under his care. Fully appreciating the import of these words, the editor of the JOURNAL wishes for all its readers a happy and prosperous New Year 1884.

WHAT CONSTITUTES A "PROFSSSIONAL CARD?"—In the *Medical Record* for December 15, the editor, in alluding to our article on Ethical Advertising, in the number of this journal for November 10, says: "We cannot but think that our Chicago contemporary is doing a serious injury to the profession by advocating for specialists and doctors generally a license which it never has been and is not now considered decent to assume." And *the license* thus spoken of, he quotes from our editorial as follows: "No one is prohibited from publishing or using a professional card as freely as he likes, simply announcing himself as doctor of medicine, and giving his residence aud office hours. * * * If he desires to limit his practice to the treatment of any particular diseases, he can say on his card that 'his practice is limited' to this or that class of diseases." Then, with characteristic ethical perversity, our friend of *The Record* exclaims: "To say that any physician 'can publish his professional card as freely as he likes,' is to take down all the barriers at once against promiscuous medical advertisement. With such a liberty one could take up *half a column* in a daily paper, and still keep within the pale of the Code."

How easy it is by simply changing the *article* "a" to the pronoun "his" in one half of a sentence, and leaving the other half out, to misapply and misrepresent the whole. And how adroitly the editor of *The Record* does it. When we said, "a professional card" could be used as freely as the possessor might wish, we were careful to add that the card should "simply announce himself as a doctor of medicine, and give his residence and office hours." To talk about filling "half a column in a daily paper" with a card containing simply a physician's name, residence and office hours is too absurd to need comment. Does our New York contemporary really desire his readers to think that he does not know the difference between a professional card proper, and a handbill or a newspaper essay?

After the earnest protest against the dangerous "license" we are represented as advocating, our friend proceeds as follows: "In the larger cities of the East, and in most, if not all, of those in the West, reputable physicians do not put their card and office hours in the daily papers, as do the quacks and abortionists. * * * In small towns it is, perhaps, well enough to allow the local physicians to insert their cards along with the dentists, carpenters and tinware men."

Ah, yes! how graciously liberal, and withal how consistent our friend shows himself. "A *license* which it

never has been and is not now considered *decent* to assume," and which "reputable physicians" in the great cities of the East and West do not practice, may, after all, be "*well enough* to allow the *local physicians*" in the "small towns" throughout the country. Well might these "local physicians" in the small towns, who constitute two-thirds of the whole profession, ask this metropolitan editor, "on what has my lord been feeding," that he and his city friends should have developed a dignity so exalted as to require one code of ethics, while another and lower one will do "well enough" for their less exalted country brethren?

Does he suppose there is an intelligent physician in all the country who does not know, that the reason why physicians in the large cities do not put their cards into the daily papers, is because it is rendered wholly unnecessary and useless by the publication annually of city Directories in which all their names and residences, and business are announced, and that too, along with the "dentists, carpenters and tinware men," and even sometimes sandwiched between the "quacks and abortionists." These Directories, revised every year, and found in every public house and permanent business place, afford a far more effectual as well as cheaper mode of advertising the members of the profession in all the large cities, than would be a proper professional card in the advertising columns of a daily paper.

Again, we are told that, "the permission to announce the 'practice limited to,' will strike sensible people as being silly, if not actually dangerous. * * * * While the attempt to make a distinction between 'practice limited,' and 'practice special' appears to us a foolish quibble."

Is it possible that our New York contemporary can see no difference between the addition to an ordinary professional card of the words "practice limited to diseases of women," by which the public are notified that no other diseases will be attended to, and the favorite phrase, "Special attention given to diseases of women," by which the public fully understand that the party claims *special* or *superior* qualifications for the treatment of those diseases, and yet may do as well as ordinary physicians in the management of any other affections? Is there no difference between notifying the public and the profession that you will attend to but one class of patients, without any allusion to special qualifications, and a notice that you will give "*special*" (which means unusual or superior), attention to that class, and yet leave yourself free to attend to whatever else may offer? The difference is so plain, that although the "permission" and "license," which *The Record* affects to regard as so dangerous to the welfare of the profession, was sanctioned by a unanimous vote of the American Medical Association nearly ten years since, yet we have not seen a single specialist's card containing the dangerous declaration. Neither do we expect to see any, simply because the ambitious young specialist who would be very glad to have the ethical privilege of offering to give *special* and extraordinary attention to a particular class of diseases, will also be very careful not to notify the public that he will attend to nothing else.

It is a little singular that an editor who boasts of such ethical *liberality* as to permit the taking of every votary of the pathys, isms, and quackery of the day, who can get a State registration license, into consultation at the bed-side of the sick, as provided by the New York Code, should have such a horror of seeing a simple professional card in print.

We have nowhere advocated professional advertising, but, as our readers very well know, have simply pointed out, in answer to direct questions from correspondents, the only way that it can be done without positive violation of the rules governing the profession at large.

SOCIETY PROCEEDINGS.

THE CHICAGO MEDICAL SOCIETY.—REGULAR SEMI-MONTHLY MEETING ON THE EVENING OF DECEMBER 17, 1883.

Dr. D. W. Graham presided. The scientific business transacted consisted in the disposal of two papers. The first, being a paper on "Alveolar Abscess Opening into the Antrum and Nasal Cavity, Simulating Chronic Nasal Catarrh," was read by Dr. John S. Marshall. It contained the following salient points regarding the origin and causes of ozæna, namely, syphilis, struma, lupus, ulceration, caries of the bones or cartilages, inflammation of the mucous membrane of the frontal and maxillary sinuses, and alveolar abscess opening into the antrum of Highmore or the nasal cavity direct. The origin of certain forms of chronic nasal catarrh with fetid mucopurulent discharges is not always easy to locate, and especially is this true if the latter enumerated cause is the primary seat of trouble, and opens into the maxillary sinus. Abscesses forming at the apex of the roots of the superior incisor teeth, bicuspids or molars, may discharge into the cavities of the antrum or nasal fossa, and range from a slight nasal discharge to a most offensive ozæna, and it is not at all uncommon to find the roots of the superior molars penetrating the maxillary sinus. Less frequently, however, the bony plate over the apex of the incisors may likewise give way, especially over the apex of the central incisor this may occur, and an offensive discharge

per se into the nasal passages or posterior nares so closely simulate chronic nasal catarrh as to entirely mislead the most careful diagnostician, whereas the real source of trouble may be a diseased tooth. During the past three years the writer has seen two patients who were suffering from this form of disease, who had been treated for months as cases of chronic nasal catarrh. The sphenoidal and frontal sinuses and the maxillary antrum may each be the seat of this morbid condition, and fetid discharges from the nasal passages be the result, *i. e.*, of the accumulation of the morbid product in the accessory cavity, which becomes distended, and the overflow escapes from the little orifice into the nasal cavity. Text books allude to this disease in a mere paragraph sometimes and undoubtedly the subject deserves more attention than has hitherto been given to it.

Antral abscess is a much more serious difficulty than the affection just described, the former causing at its inception rigors and fever, and involves much more of the adjacent structures, periosteum, etc. In antral abscess the pus may be retained between this membrane and the bone, causing absorption of the walls of the antrum; and it may open into the mouth, orbit, or through the external surface, and cause hideous deformity. Extensive necrosis of the maxilla often follows, and it may extend to the ethmoid, lachrymal, palatine, and inferior turbinated bones, with cerebral abscess, unless early recognized and interfered with by surgical means.

When a dental abscess opens into the maxillary sinus, there may be danger of septic poisoning, if the secretions become foul and no other outlet is present. If this should occur, it will be attended, of course, by serious constitutional symptoms. When it escapes into the nose the discharge will be unilateral, in its always being from the same nostril, and most abundant when a patient is lying upon the opposite side.

After the cases, with the symptoms, history, etc., etc., had been cited, the paper concluded with the treatment, which consists in syringing the cavity of a tooth and abscess through the pulp canal with warm carbolized water, 2 grs. to the ounce, once daily, and packing the tooth with carbolized cotton, and sealing it in with gutta-percha stopping to exclude external moisture. Sometimes the buccal roots can be explored with a fine probe, by passing it upwards for an inch and three-quarters. Water can be thrown into the antrum of Highmore through the roots of the teeth, and the fluid will escape into the nose. A tooth always needs to be extracted, if not already missing, and we then discover, most likely, that the pus will escape into the mouth through the alveoli, and that the ends of the buccal roots are somewhat rough, and portions already have been removed by absorption. A few weeks' time of treatment in this manner usually results in a most satisfactory improvement or entire recovery of the patient.

The paper elicited considerable discussion. Dr. T. W. Brophy said that he had seen and treated a great many cases similar to those cited by the writer of the paper, that had previously been treated by physicians for nasal catarrh. He also illustrated his remarks by giving a method by which he was treating a case at present, and draining the antrum through an opening into the mouth by a metal tube or canula. The patient has been under his observation for ten months, and was for four months previously treated for the nasal difficulty alone, by a physician having a large practice. The case is now almost entirely well. I think the discharge of pus into the nasal cavity occurs more frequently from the incisor teeth than from the molars, and necrosis frequently results from the alveolar abscess that at first has formed at the roots of the teeth, and sometimes involes the entire upper maxilla. He was much pleased with the paper, and had been much interested thereby. Dr. Edmund Andrews inquired of the author what form of syringe he used in treating this class of cases? and what form of point the syringe had?

Dr. W. W. Allport stated that the paper presented by Dr. Marshall was well prepared and timely. That similar cases to those mentioned by him do sometimes occur there is no doubt, but not so frequently that any one individual sees and treats a great many of them, as Dr. Brophy states he has done. I think that I am an ordinarily careful observer, but during my thirty-five years of practice, I have seen but very few of such cases—not to exceed five or six—and I can hardly see how it is that any one man has treated so many cases similar to those mentioned in the paper as the gentleman preceding would have us infer that he has. Dentists frequently have fistulous openings and occasionally a diseased antrum to treat caused by alveolar abscess. But alveolar abscess simulating nasal catarrh is met with seldom, and I think Dr. Brophy has misunderstood the idea conveyed in the paper.

Dr. Robt. Tilley stated that he has treated catarrhal troubles of the ear that had been primarily connected with the teeth, but a case had never occurred in his practice of catarrh of the nose originating from the teeth where perforation had occurred, as was described in the paper, and he took pains to examine the teeth and mouth carefully in making his diagnosis. He would like to inquire, without naming any one, if dentists had ever tried using the remedy peroxide of hydrogen in "syringing out" this kind of pus cavity? He knew it to be an efficacious remedy for dentists to use, and suggested it as a valuable agent in the treatment of alveolar abscess. Twelve volumes of oxygen in solution is used in full strength by oculists in Paris in treating eye affections, and he presumed it could be used in the same strength in treating these abscesses.

Dr. Brophy arose to add to his former remarks that he did not wish to be understood as saying he had seen more cases of alveolar abscess than other dentist, as might be inferred from the remarks of one of the gentlemen who had the floor a few moments ago. He, however, would verify the statement he made at the beginning of the discussion—that he had met with a good number of cases of this variety, and would at an early period present a paper on this subject before this Society, which he would be pleased to do as soon as he can have the drawings made to illustrate the facts

Dr. Allport said, regarding the use of peroxide of

hydrogen, it is coming into general use by dentists. He knows it to be an exceedingly useful remedy, as he has practiced using it a good deal, and concluded by saying the author of the paper, he thought, had ably called attention to an important subject this evening; one that is generally overlooked in diagnosing nasal catarrh.

Dr. Marshall closed the discussion by describing the kind of syringe used, as one speaker had inquired about it, by saying it was the ordinary dental syringe fitted with a flexible metal point. He stated that the peroxide of hydrogen was in general use, although he had not used the remedy in the treatment of this class of cases; but certainly should regard it as valuable in the treatment of blind alveolar abscesses. Regarding the cases he had reported, he said they had previously been under the observation of intelligent and well educated physicians. The object of the paper was to call the attention especially of the medical profession to one of the most obscure causes of fetid nasal catarrh—a cause which in a majority of cases, he thought, was overlooked by them.

The following is the substance of a paper presented by Dr. Wm. L. Axford, on "Packing-House Wounds," from observations made during the past three years. The bad consequences ensuing from very slight wounds on the hand and forearm (oftentimes amounting to a mere scratch), when inflicted by knives used in packing-houses, are familiar to many of you. When the skin has been cut through and the cellular tissue opened, an intense cellulitis, terminating in the formation of large quantities of pus, requiring free incisions, has been almost invariably the result. From a small cut in the back of the hand, a cellulitis extending half way up the forearm is not an uncommon result, and cases under observation have occurred where the inflammation extended to the elbow. If the sheath of a tendon be opened, or the tendon cut, sloughing is the usual termination. If the wound extend deeper and the periosteum is cut, nearly every case will be followed by periostitis with necrosis. The cause must, of course, be the septic material conveyed into the wound from knives used daily in cutting meat, which probably are rarely cleaned with care, and never disinfected, although they may be ground and washed daily. Wounds are of daily occurrence at some of these large houses, and from past experience I am led to think we may expect the worst consequences to follow where the knives used by "shavers"—*i. e.*, those employed in removing the finer hair from the bodies of the animals after they have passed through the "scraping machines." (The "American hog," of course, being the animal alluded to, that undergoes this sudden and complete metamorphosis).

The wounds seem to pursue the same destructive course and resist antiseptic measures, as if no treatment were adopted. The treatment of wounds of this nature is, when necessary, to approximate the edges with sutures, then by using freely either carbolic acid, solutions of eucalyptol, or iodoform, all of which have been tried, and still, union by the first intention has never yet occurred in the practice of the writer.

A better plan might be to put aside the idea of securing union by the first intention, (which is but problematical) and direct our measures towards preventing the inflammatory consequences by arresting the spread of the supposed poison through the tissues, or, in other words, treat these cuts from the first as poisoned wounds, and try to prevent the further invasion of the septic material. To do so, if called immediately, apply thoroughly to the cut the actual cautery as the best means of destroying the poison. This heroic method the writer is convinced will diminish the suffering of the patient, and lessen the actual inconvenience so far as time of recovery goes.

Perhaps, if we inject antiseptics, such as carbolic acid, tr. iodine, or other solutions, into the tissues about the wound, that they might take the place of the actual cautery, but their efficacy as adjuvants to the treatment by the cautery in fresh wounds can be better tested by using them after the more heroic method of searing the surface first, has been done.

If, however, some time has elapsed since the injury before we are called, it would be more advisable to dispense with the cautery and trust entirely to the injections, and environ the wound by a layer of some reliable antiseptic dressing.

Among those who discussed the paper was Dr. E. Andrews, who stated that he was frequently called to attend severe cases, the result of so-called "packing-house wounds." Some patients are more violently poisoned than others. He recalled a case of a man whose foot had been injured by a machine that is used in an "offal factory" to grind the bones of the animals slaughtered, and the foot was completely destroyed. The leg was at once amputated, but in 12 hours the flaps mortified, and the lower half of the thigh was distended with gas. In another 12 hours the entire thigh was tympanitic, and a few hours more the man died, not so much from shock as from being poisoned to death. Another case he saw, was where a man had been cut by a cleaver (used in a packing-house) in the lower portion of the "shin." It pursued the same course to a fatal termination. The juices that oozed from the stump after he amputated the leg contained large numbers of bacteria, and the case presented what he termed septicæmia with a vengeance. He also gave the history of a third case with the same final result, death. Some authors termed this traumatic gangrene; others, gangrenæ septicæ. It is a virus, but does not think many of the hogs have this virus.

Dr. Robert Tilley thought that no advantage could be gained by using a cautery in these cases, if amputation proves to be of no avail, and he thought a simple hot poultice would be the better method to destroy septicism, because bacteria do not thrive at a temperature a little above that of the body, or to keep a hot appliance continually to the wound. He had treated a number of cases of wounds received in soap factories, none of which had septicæmia.

Dr. Graham had seen a number of chronic cases of the kind of which the paper treated, and thought part of the virulence is due to the way this class of people live, as they live in a vitiated atmosphere at

their homes, also the peculiar modes of the individual in their hygienic care of themselves.

Dr. Axford thought the cause of these poisonings was due to the knife being dipped in blood nearly constantly by butchers, and is the carrier of the virulence instead of the hog, at least in most of the cases, and that we should be on the alert for the after consequences, which are most sure to arise. He was convinced that every man wounded at these places by the knives used there is actually poisoned.

L. H. M.

PROCEEDINGS OF THE SUFFOLK DISTRICT MEDICAL SOCIETY.

[Section for Clinical Medicine, Pathology and Hygiene.]

ALBERT N. BLODGETT, M. D., SECRETARY.

SUDDEN DEATH DUE TO HÆMORRHAGE FROM THE HEPATIC VEIN.

Read before the Section for Clinical Medicine, Pathology and Hygiene, of the Suffolk District Medical Society, Nov. 14, 1883.

Dr. A. F. Holt, Medical Examiner for Middlesex, presented a paper upon a remarkable condition found at the judicial autopsy of a patient dying under peculiar circumstances. The cause of death here reported, namely, hæmorrhage from the hepatic vein, has not, so far as known, been previously observed. The case occurred in the practice of Dr. Dow, of Cambridge, from whose notes the clinical history as here given has been copied.

J. C., an Englishman, fifty-six years of age, large, and strongly built, though slightly hunch-backed, died May 15, 1883. For the last six or seven years of his life he had been engaged in a small kindling wood trade, doing some of the manual labor required by such a business himself. For the ten years before this time he had been a police officer.

Ten or twelve years before his death he began to have severe attacks of colic. These continued to occur at irregular intervals during his life, and for the last six or seven years he was never quite well, although able most of the time to attend to his business. During these years he had consulted a large number of physicians. Most of these pronounced his trouble gall-stones, but some of them dyspepsia, and still others some obscure disease of the liver.

Seven days before his death, while in Boston attending to some business, he was suddenly prostrated with a very severe attack of pain in the region of the stomach, nausea, and faintness. He was taken to his home in Cambridge in a carriage, and his physician, Dr. Dow, was immediately summoned, who found him suffering from severe pain, vomiting at at short intervals, pale, and faint. The pain and faintness continued until evening, he having been taken sick about noon, when the doctor was hastily called again. He found him vomiting blood in the form of very large dark clots. This continued at short intervals about one hour, when it ceased. A little over three pints of blood was vomited at this time. The pain and faintness continued for three days. Although these symptoms were somewhat relieved by stimulants and opiates, at the end of this time he was again attacked with the vomiting of blood, as before, in the form of very large black clots. This continued at short intervals until nearly two quarts had been ejected, when it suddenly ceased; and after this he was very weak, faint, and nearly pulseless. The pain continued a few hours after this vomiting, when it ceased. Although his mind was clear, he did not rally, but gradually sank, and died forty-eight hours later, or a little less than seven days from the commencement of the sickness. No blood was at any time passed by the rectum.

Autopsy 23 hours after death. There was no sign of decomposition; rigor mortis well marked; body that of a large, muscular man, and quite fat. There was a thick layer of fat over the abdomen. All of the abdominal organs were imbedded in this tissue. The walls of the chest were expanded in front and at the sides to such an extent as to make quite a deformity; and all the organs of the chest were above the fifth ribs. There was a slight adhesion of the left lung to the chest wall at the top, otherwise the pleuræ were everywhere clear, pale and glistening. Pericardium normal, but on opening this sac the heart was seen to present a noticeably peculiar appearance, the right ventricle being distended so as to make a rounded prominence on its upper part near the auriculo-ventricular junction. The right auricle was also distended. Both of these distensions felt elastic to the touch. On opening this side of the heart there was an escape of a puff of gas, and the walls of the organ immediately collapsed. There was no blood in either of the cavities. The right ventricle was a little dilated, and its walls were slightly thinner than normal. Left side of heart empty. The whole organ was rather large. Its tissues were pale, but of a uniform color. The valves were in every way healthy, and but little blood flowed from the cut ends of the large vessels.

The lungs were very broad and thick, making up in these dimensions what they lacked in length. They were everywhere of a uniform pale color, with darker marbling, except the dependent portions, which were a little reddened. They were also everywhere crepitant, the cut surface showing nothing abnormal, except that the blood-vessels of these organs contained but little blood. The mucous membrane of the bronchi and trachea was pale, and in places smeared over with a little frothy mucus. The spleen was more than twice the usual size. It was fairly firm. Sections showed it of a dark-red or blackish color, and the pulp largely increased. But little blood flowed or could be squeezed from the vessels. Both kidneys were imbedded in large masses of fat. They were a little larger and firmer than usual, the capsules slightly adherent. The cut surface showed the cortical part of a uniform pale red color, and of proportionate thickness. The tubular part was of a bluish tinge, and the blood-vessels could be seen as red lines. These organs contained but little blood. Ureters and bladder healthy. The latter contained a little urine. The stomach was large and flabby, and contained about a pint of liquid food. It, as well as parts of the transverse colon, was firmly adherent to the

lower border of the liver. All its tissues were normal in appearance, except that part where it was attached to the liver, which was a little reddened. The pylorus readily admitted the thumb. The duodenum was empty. Opposite the head of the pancreas could be seen the papilla marking the entrance of the common bile duct, as large as the end of the finger, and projecting into the gut. The opening of this duct would readily admit a pencil. Just inside the duct, lying loosely in the canal, was a gall-stone of such a size as to render it a little difficult to force it through the opening into the intestine. The common duct increased in caliber as it approached the liver, until it and the hepatic duct were dilated into a sac or pouch of about two ounces capacity. The walls of this pouch were very thick and hard, and there was a deposit of a dense tissue around them. At the lower end of this sac, near where the gall bladder entered it, was a cup-shaped depression the size of half a chestnut. When a little water was poured into this a shreddy mass floated up, being attached to the sides and bottom (recent ulceration). On the upper side of this dilated duct, and immediately opposite where the blood-vessels entered the left lobe of the liver, was a similar spot of ulceration, somewhat larger and irregular in outline. On handling a little blood was seen to flow from the bottom of this depression, and an opening was readily found leading directly into one of the vessels entering the left lobe of the liver.

I believed this to be a branch of the hepatic veiu, but all of the tissues in this vicinity were bound together in such a confused mass I was not quite certain. The gall-bladder was much thickened, and contracted in such a way as to make its cavity very irregular, and of a capacity of not more than two or three drachms. Its mucous surface had wholly lost its honeycombed appearance. The opening between it and the sac was wide enough to readily admit the finger. Both the gall-bladder and sac, when opened, contained a little bloody fluid.

The right lobe of the liver was smooth and glistening; rather large, and a little darker colored than usual. The cut surface showed its cellular structure slightly fatty, and its blood-vessels nearly empty. The left lobe of this organ presented a remarkable appearance. It was of a uniform greenish-brown slate color, smooth, but not glistening; and the contrast between it and the right lobe was very striking. It felt firm. The cut surface was of the same uniform greenish-brown color. All appearance of structure had disappeared. A piece of this lobe could readily be broken with the hands: and the fractured surfaces had much the appearance of a nearly dried piece of mud treated in the same way. The larger blood-vessels could be made out in the mass. They were filled with a dryish brown-red material that remained formed when turned out of the vessel: but readily crumbled in the hand into a coarsely granular mass. The main vessels entering this lobe of the liver near the ulceration above described were filled with the same material.

The large intestine contained a little solid and semi-solid yellowish fæcal matter. The small intestine was nearly empty, but contained a little of the product of digestion, of a yellowish color. Nowhere in this tube was there anything that looked like blood.

Unquestionably the source of the hæmorrhage was this open blood-vessel supplying the left lobe of the liver, the blood readily finding its way into the duodenum by means of the largely dilated duct and its opening into the intestine, and through the rather open pylorus into the stomach. Why all of the blood should take this course and none of it go down the intestinal canal, as it apparently did not, is one of the points in this case seemingly worthy of discussion.

Of course the gas accumulating in the intestinal canal after death found its way by means of the same open vessel to the right side of the heart.

Hæmatemesis, with the blood coming from such a source, must be exceedingly rare, and so far as I am able to learn, this case is unique.

The peculiar condition of the left lobe of the liver I have never seen before. I believe it to have been caused by a complete cutting off of the blood supply, producing a necrosis of the part.

Dr. F. A. Harris, Medical Examiner for Suffolk, said that the strange and heretofore unknown occurrence recorded by Dr. Holt is valuable in making us acquainted with a new causation for sudden death. The medical examiner is required to investigate all cases of death of a sudden or suspicious character, and it no doubt may happen that cases are returned as due to disease of the heart, no other ascertainable lesion existing, which may be due to some cause not hitherto reported and entirely unknown. In many cases some obscure disease might easily be quite overlooked. Among such causes is aneurism, which, even when of small size, may at times obstruct the nutrition, or disturb, and at length entirely suspend, the function of important organs. In one case an unsuspected small aneurism of the internal carotid caused obscure cerebral symptoms, and finally death from pressure upon one of the pneumogastric nerves. Aneurism of the arch of the aorta may be suspected from the occurrence of disorders of the vocal apparatus in the larynx not due to any organic local disease, when the existence of aneurism is not evident from any other symptoms. In such cases the existing disease may be so slight that it may escape observation at the autopsy, and the death of the patient be charged to some other cause. The medical examiner is required to give a cause of death in all suspected cases, the law requiring him to ascertain the manner by which the patient met his death. For this reason, it for no other, all cases of death from rare diseases should be reported, for the benefit of State and local Boards of Health, as well as for statistical and other purposes.

Dr. Fitz considered the paper extremely interesting, and was glad to have heard the report of so rare a case. He said he had never met anything of a similar nature in his personal experience. Gall-stones may occasionally become a cause of ulceration of the gall-bladder and secondarily lead to much further mischief. The reported condition of the liver is very remarkable. Such a change is occasionally observed

in the lung, as a wedge-shaped necrosis of a part of the pulmonary structure due to embolism of some vessel. The necrosed portion then quickly becomes the seat of gangrene, and generally goes on to a fatal termination. The presence of gas in the heart is interesting. The opinion of Dr. Holt that the gas was formed from decomposition after death might be criticised, as it might quite as easily enter the venous channels during life.

Dr. Webber asked if gas, entering the circulation before death, would not be evidenced by a frothy condition of the blood on opening the heart.

Dr. Fitz replied that while this is often the case, it is not necessarily so. It may escape as a free gas. Atmospheric or gas embolism is sometimes observed in other parts, especially in the lungs.

Dr. Prince observed that pancreatic apoplexy[1] may be accompanied by many of the symptoms mentioned in this paper, and quite generally vomiting occurs.

Dr. Church, of Cambridge, presented the following

NOTES OF A PECULIAR CASE IN WHICH THE AUTOPSY SHOWED CONGENITAL ABSENCE OF THE LEFT KIDNEY.

On Tuesday A. M., November 6, I was called to attend Mrs. L., a Swede, in confinement. On arriving at her house I was shown into a room containing a bed, and upon it lay a well-dressed woman, apparently forty years of age; presuming her to be Mrs. L. I approached the bed, and made the inquiry if she was the person to whom I was called, to which she responded in the negative, saying that she was a friend of Mrs. L.'s, and had arrived from Vermont the evening previous, and had not felt well since her arrival. Complained of pain in the stomach and back, with slight headache, but thought she had taken cold, and rest would suffice to restore her to usual health. I then passed on to attend Mrs. L. in an adjoining room, and did not see Miss A. until three or four o'clock in the afternoon, when I obtained the following history: She was born in Sweden; was forty-five years old; came to this country two years ago; had always been well excepting "slight touches" of dyspepsia and occasional sharp pains in the epigastrium. Menopause fully established before she left Sweden. Had worked as a domestic in a farmer's family in Vermont for nearly two years. Said that the bowels were regular, and appetite usually good. Never used stimulants or narcotics. When asked if she had not better have some medicine she said no, as she thought rest and diet would be all that was necessary. Saw her on the following morning while visiting Mrs. L. Said she had not slept during the night previous. Bowels and bladder had been evacuated during the night, but the pain in the back and stomach had not subsided, and she had vomited twice during the morning, and had an attack of epistaxis and severe headache. The tongue was very dry, and in the center covered with a thick, brown incrustation; some sore throat. Examination of the chest gave negative results; the only peculiar feature was the feebleness of the heart sounds. Pulse 88; temperature 96.5° F.; respiration normal; slight tenderness on pressure in the right hypochondrium. Warm applications and stimulants were ordered, and at noon she got up, went into the kitchen, and drank some milk and tea. I did not see the patient again until Thursday morning at 9 o'clock, when I found her comatose. I was told by the people in the house that she had slept all night. At the time of my visit the respirations were heavy, tongue and mouth as dry as parchment, and mouth and throat full of a mixture of dried blood and saliva; pulse 88°; temperature 95° F.; pupils dilated; marked pallor, and a peculiar pinched expression of the face. Feeling that the case would prove fatal, and knowing that the patient had no relatives or friends in this country, I asked City Physician Bryant to see her. Pulse, at the time of visit—12:30 P. M.—90; respiration normal; temperature 95° F.; patient profoundly comatose. At 5 P. M. she became pulseless, and expired at 9 P. M.

Examination of the urine gave the following results: color pale; reaction neutral; specific gravity 1010; large trace of albumen; urea slightly diminished; phosphates and chlorides diminished. Microscopic examination showed triple pho phates, no pus or blood, a few degenerated renal epithelium cells, but *no casts* or *fat*.

Feeling that either from imperfect memory or inability to understand or express herself in our language the history given me by the patient was incorrect, I wrote her employers at Williamstown, Vt., and obtained the following additional history:

First. That she had suffered much from what had been diagnosticated by a resident physician as dyspepsia.

Second. That one year ago she had an illness of five weeks. Diagnosis, "ulceration of the lung and slow fever." That previous to coming into their employ she had visited the Massachusetts General Hospital for nausea and suppression of menses, and was thought to be pregnant.

Third. During the last year, though her appetite was good, she complained of feeling weak, of having headaches and frequent attacks of severe epigastric pains, and cramps in the lower limbs, also of some dizziness.

Fourth. That large quantities of urine had been voided, especially during the night, for a long time.

Fifth. That when she arrived at Mr. L.'s on Monday night she complained of feeling very dizzy, and trembled violently.

Sixth. That for the past eight or nine months the patient had complained of sleepiness during the day, and imperfect vision.

The autopsy was made by Medical Examiner A. F. Holt, Saturday morning, November 10, to whom I am indebted for the following report:

The body was that of a Swedish woman, 45 years of age. The heart was enlarged, particularly the left side. The left lung was adherent throughout. Spleen normal in size and appearance. Left suprarenal capsule in its usual position, but a little larger than normal. No left kidney, renal artery, or ureter could be found, or anything to indicate that they had

[1] A report of two cases, with references to fourteen other cases, was read before the Section May 6, 1882.

ever existed. The right kidney is the one here shown. It is very small, not larger than a large hen's-egg, and shaped much like one. The whole organ feels firm and rather hard. The capsule is much thickened and adherent. The cut surface, when removed, was of a uniform grayish color, with darker mottlings. The line between the cortical and tubular parts could not be made out at that time; now, as it has been in dilute alcohol for a day or two, it can be distinguished. The greater part of the organ seems to be made up of the cortical portion. The whole organ, without doubt, has undergone some marked change, probably interstitial nephritis, but of this I am not certain, as no microscopic examination has been made. The liver was a little larger than normal. Stomach and intestines apparently healthy.

In my experience in making autopsies only in one other case have I found but a single kidney; this was in a man, sixty-five years of age, who died of cancer of the stomach. In that case the single kidney was very large and healthy, and, as in the present case, it was the left kidney which was wanting.

I believe that both of these cases were congenital.

Dr. Church also exhibited the vermiform appendix of a patient who died from perityphlitis and peritonitis, and in which the cause of the disease was found to be an ordinary brass pin, which had been swallowed, had passed through the stomach, duodenum and the entire length of the small intestine, and had entered the vermiform appendix, head downward where it had awakened a violent inflammation with the subsequent fatal result.

Adjourned at 10:40 P. M.

BOOK REVIEWS.

PHYSICIANS VISITING LIST, 1884. P. Blakiston, Son & Co., Publishers, Philadelphia.

This convenient pocket memorandum and case book has appeared regularly for the last thirty-three years. It is too well known by the general profession to need any special description.

PHYSICIANS POCKET DAY BOOK, designed by C. HENRI LEONARD, M.A., M.D., Detroit.

This is meant to cover much the same ground as the last. It, however, lacks the dose tables and such information as is in the other. Both of these books are well bound and of convenient size.

THE RADICAL CURE OF HERNIA. A PLEA FOR THE CURE OF RUPTURE, OR THE PATHOLOGY OF THE SUBCUTANEOUS OPERATION BY INJECTION FOR THE CURE OF HERNIA. BY JOSEPH H. WARREN, A.M., M.D. Boston: James R. Osgood & Co.

This is a small paper-covered volume of 125 pages, written apparently to uphold the injection method of treating rupture for radical cure, and perhaps also to identify the author as the legitimate successor of Dowell and Heaton, who formerly had a sort of proprietary hold upon the operation.

At the time of the publication of the supposed valuable secret of this method, it was very extensively tested by surgeons and by itinerants all over this country, as similar methods have been in Germany.

The operation, although a safe one, and the best so far tried, has met with a discouraging number of failures.

That the operation cures some ruptures of course is well understood, but it is also becoming evident that its successful cases, are those in which the simple wearing of a truss often makes a radical cure, *i. e.*, young persons.

Long after the operation has been performed a truss must be worn—a year at least the best writers think—after which time a surprising number of cases relapse and eventually are not improved. Such patients of course deceive themselves and their surgeon into the belief that a brilliant cure has been effected. Months usually elapse before a recurrence of the hernia, and the surgeon may never hear of the final result.

The constant appearance of ruptured patients at clinics and truss establishments, who have tried the injection method with only temporary benefit, is an argument not easy to answer by those who have put forth glowing promises and reports of cases. No case ought to be reported among "cures" until several years have passed by without a return. A prominent Philadelphia surgeon—who was once quoted by the originator of the injection method as having seen brilliant successes from it—afterward declared it as his opinion that no undeniable and permanent cure had ever been made by it.

A MANUAL OF PATHOLOGY. BY JOSEPH COATS, M.D. Illustrated. Published by H. C. Lea's Son & Co., Philadelphia.

This manual consists of a single volume of about 800 pages. Its subject-matter is treated of under the headings of General Diseases and Diseases of Special Organs. Under the head of General Diseases are described affections of the circulation and of the blood, inflammation, retrograde metamorphosis, hypertrophy, repair, regeneration, infective tumors, tumors or morbid growths, and parasites. The largest part of the work is devoted to the diseases of special organs and systems. The book is well written and very well illustrated with wood-cuts. It presents clearly the most generally accepted views of modern pathologists. In the chapter on parasites, the author considers quite freely and very fairly the theories and facts pertaining to bacteria. First, the natural history of bacteria is briefly considered, and the methods of detecting them are described. Their influence on living tissue is then considered. Septicæmia, whose bacterial origin is pretty well proven, is described in detail. In regard to the pathogenetic powers of bacteria in acute specific diseases, the author places himself on conservative ground, although he gives full descriptions of the bacteria that have been found in them. He says in regard to the matter: "Bacteria have been found in the tissues in a large number of acute diseases in man, and most of these diseases belong to the class of zymotics. Among the diseases in which, up to the present, such organisms have been seen, may be mentioned small-

pox, scarlet fever, measles, diphtheria, acute rheumatism, erysipelas, typhoid fever, typhus fever, splenic fever, relapsing fever, pneumonia, leprosy, tuberculosis. All that is asserted, in the meantime, is that bacteria have been observed in these diseases; it is not meant that each of these diseases depends necessarily on a specific form of micro-organism."

The work, as a whole, is creditable to the author, and will prove a useful manual to English readers.

DOMESTIC CORRESPONDENCE.

PHILADELPHIA LETTER.

There has probably not been for many years a winter characterized by such indefatigable exertion on the part of the medical profession of Philadelphia as the present. The reason for this unusual activity lies in the fact that a new element has been introduced into the methods of teaching, that of post-graduate instruction. A number of gentlemen from the rank and file have been called upon to assume the responsible position of teachers, and as they are theoretically well qualified for the duties, there is a commendable spirit of rivalry existing which promises well for the future. The rivalry to which we have referred is nowhere more noticeable than at the meetings of the County Medical Society, which are held weekly and largely attended.

For the purpose of giving the readers of the JOURNAL an idea of the character and amount of work done at these meetings, it may be worth while to present some notes picked up from the last two.

On the 12th inst. a conversational meeting was held, the principal paper being that of Dr. Arthur V. Meigs, who selected as his subject, "Proof that Human Milk Contains Only about One per cent. of Casein, with Remarks upon Infant Feeding," a somewhat condensed summary of which would run about as follows: A paper relating to this subject read before the society nearly a year ago had been adversely criticised by reason of the peculiar views then held, but during the interval he had been engaged in further experiments, and so far they had only confirmed the statements then put forward. He said the methods of analyses by different chemists were not free from error, and besides, many of them had started with incorrect premises. As a rule, it was believed that the amount of sugar in milk was small and the casein large, and two reasons were given for this apparent condition, viz.: that there were variations in the milk itself or that the chemistry was faulty. He believed that if the proper precautions were observed, the amount of sugar in cow's milk would be found to be uniform and large, while on the other hand, the amount of casein would be small. By means of the necessary chemical reagents he had been able to obtain the sugar in a crystalline form, and so far as he was concerned, the matter was fully set at rest. Although cow's milk had been objected to on account of the casein it was supposed to contain, his experiments had proven conclusively that this was erroneous, and in this respect opinions were diametrically opposed. An analysis of forty-three samples of human milk, the tables showing the results being presented for inspection, has convinced him that cow's milk when diluted does not supply the place of human milk. The reaction of the former is acid, while that of the latter is alkaline, an important fact which has thus far been overlooked, as the character of the coagulum formed by milk depends largely upon its acidity. Another point to be observed is, that cow's milk contains much more casein, a substance which though but little known, has been found when subjected to the process of drying to become insoluble. The reasons for failure are now apparent, and the want of success can be accounted for, and although much time has already been given to the study of the matter, it is still evident that further investigations are necessary.

A formula was presented for the preparation of an artificial food which shall meet the requirements of the case, but as the paper will be published in full, its reproduction here will not be attempted. It may be added, however, that it will be found most satisfactory in the preparation of the artificial food to use good, fresh cow's milk

The paper of Dr. Meigs is the result of long and careful investigation, and the principles laid down will undoubtedly have the effect of establishing a new era in the methods of infant feeding.

A clinico-pathological meeting, held on the 19th inst., from the character of the papers presented, may appropriately be termed a medical symposium, the entire evening having been devoted to the reading of papers on, and the discussion of the diseases of, the kidneys, more especially, however, with reference to albuminuria. The only paper referring to therapeutics in renal diseases, was that of Prof. Bartholow, the subject being, "The use of Nitro-Glycerine and Chloride of Gold and Sodium in Albuminuria."

Starting with the proposition that albuminuria was essentially a neural affection, he pointed out two conditions found to exist: first, that in which the vascular supply was deranged by reason of the contraction of the vessels, a circumstance due to the heightened activity of the sympathetic nervous system. In such cases, nitro-glycerine, by removing the tension of the peripheral vessels, lessened the work to be done by the heart, and had the effect of equalizing the general circulation, thus theoretically favoring recovery, and clinical evidence, he said, had confirmed this opinion. Second, a condition obtains in which there is an increased tissue formation, a hyperplasia, and these cases, when seen at an early stage, might be greatly relieved, if not entirely cured, by the appropriate administration of the chloride of gold and sodium, a remedy which in some respects resembles the action of corrosive sublimate. It is a remedy which appears to have a selective action on the sexual functions, but neither this nor its supposed value is a modern discovery, as the use of gold has been referred to by some of the most ancient writers; and in opposition to a generally received opinion that it was first used by Hahnemann, we find quite an interesting account of its history in that curious but antiquated work, "Burton's Anatomy of Melancholy," published, you know, long before the days of Hahnemann. Like all the productions of Prof.

Bartholow, this one partook of the usual features; it was clear, concise, exact, and the logic of his arguments unassailable.

The paper, however, which developed the greatest amount of discussion, was that of Dr. James Tyson, the subject being, "Some Recently Suggested Delicate Tests for Albumen." Dr. Tyson covered the ground pretty thoroughly, so far as known, concerning the substances to be used in testing, and amongst the number reference was made to picric acid, an old method which has recently been brought forward anew, and the drift of discussion seemed to rest particularly on this latter preparation. Along with others who gave an account of their experience with its use, none seemed to cover the ground more thoroughly than Dr. John Aulde, who is reported as follows: Having given this subject some study and investigation recently, I may be able to add something to what has already been said by the gentlemen who have preceded me. That a saturated solution of picric acid is a delicate test for albumen in the urine, none will question; but there is an objection to it, and the same may be said in regard to nitric acid, namely, that it stains the hands and clothing of the operator. The points in its favor are, that a solution can easily be prepared, and it is safe to handle; but there are chances of error, and unless these are first eliminated the physician may be misled by this method of examination at once.

If a quantity of albuminous urine is placed in a test-tube, and a single drop of the solution allowed to fall upon it, a distinct coagulum will be formed, but when there is an excess of albumen, agitation of the mixture will cause it to be readily dissolved. If there are peptones in the urine, the addition of picric acid will be followed by a precipitate, and contrary to the opinion of Dr. Tyson, Gerhardt has frequently observed peptones in urine free of albumen, either as a forerunner or consequence of ordinary albuminuria, while Senator states that peptones exist in every albuminous urine in slight quantities. Another source of error arises from the use of quinine, a substance excreted largely by the kidney, and it has already been stated that a weak solution of the alkaloid, when brought in contact with picric acid, will show the characteristic reaction, but there are other alkaloids which will act in a similar manner, although I am not able at present to name them. The presence of urates will likewise throw down a coagulum with this solution, but not until after some minutes, but it should be stated that there is a material difference between this and the coagulum formed by albumen. In the case of urates it is crystalline, while that of albumen is granular.

It will not be out of place here to call attention to the possibility of laying to much stress on the single fact that there is albumen in the urine, as it has been shown that it does exist in normal urine. The recent work of Dr. Millard, entitled "Bright's Disease," is authority for the statement that in a series of examinations conducted by French surgeons, the urine of soldiers supposed to be in good health and free from hereditary taint, discovered the presence of albumen in no less than eighteen cases out of one hundred.

Permission having been granted to ask a question, Dr. Aulde said, Dr. Tyson has related the case of a patient who was under treatment for some time, but the urine, although examined repeatedly, failed to discover the presence of albumen by the usual tests, but he says that when picric acid was added a coagulum was formed at once. He has further stated that the treatment embraced the use of the salts of potassium, a remedy which is now well known to cause this peculiar reaction when excreted by this channel, and the question is this: was it really albumen, or does the use of these salts furnish still another source of error.

The unusual marked success which has attended the use of the oleates, has prompted the writer to continue his investigations at the Philadelphia Hospital for Skin Diseases, which has resulted recently in the formation of oleate of nickel, and the development of a therapeutic value to the oleate of tin. This new chemical oleate is similar to the oleate of tin, quinine and others, which *I first described* as *salts*, in 1879, before the Pennsylvania State Medical Society, and again in 1881. It was manufactured by Dr. L. Wolff, of this city. It is prepared by the double decomposition of the nickel sulphate and sodium oleate, the chemist using the oleic acid of the U. S. P. in making the latter ingredient.

I might add in this connection that oleates made from the impure oleic acid, the so-called red oil of the candle-makers, while cheaper, are neither certain or decided in their action, and will often set up an irritation upon the skin when the opposite effect is desired. After some years of patient and careful investigation of the oleates, and a comparison of the therapeutic results of the salts made from the pure oleic and U. S. P., and the impure or red oil, has resulted in positive and excellent results with the former, and with disagreeable and very often irritating effects with the latter. I refer especially to this subject on this occasion, as many of the oleates now offered by manufacturers, and from which bad results have followed, are due entirely to the irritating action of this impure oleic acid or red oil.

The Oleate of Nickel, just mentioned, is a greasy amorphous, waxy, tasteless substance having most decided astringent action, almost bordering upon the effect of a caustic. I have tested it upon some chronic cases of the eczema of the extremities in which the skin was hard and of a leathery state, with some good results. The salt was used in from five to twenty grains to the ounce of lard. It is now also being tried upon some old ulcers and cancerous affections of the skin in the out-door department of the hospital.

The oleate of tin already alluded to is prepared by the double decomposition of the tin chloride and sodium oleate. It is of a greyish-yellow appearance, unguent consistence and possesses a metallic odor. It has been found to be of great utility in giving luster to diseased nails that have been abnormal or deficient in their growth. It assists by its local action in overcoming a brittle, split or soft condition of the nails that often follows certain skin affections and external injuries. It forms, especially when combined with a little carmine, an elegant article of toilet for the nails

and surrounding cuticle, giving the parts a beautiful polish. It assists in relieving by its astringent action the ragged and attenuated skin at the base of the nails, or what are known as agnails, that are so often observed from neglecting these important appendages.

FROM WASHINGTON.

The following bills of interest to medical men had been introduced in Congress previous to its recess for the holidays:

Senate Bill 403. Provides for the erection of a brick and metal fire-proof building to be used for the safe keeping of the records, library and museum of the Surgeon-General's office of the United States Army, to be constructed upon the government reservation in the City of Washington, in the vicinity of the National Museum and the Smithsonian Institution, on a site to be selected by a commission composed of the architect of the Capitol, the Secretary of the Smithsonian Institution, and the officer in charge of the State, War and Navy Department building, and in accordance with plans and specifications submitted by the Surgeon-General of the Army and approved by said commission, the cost of the building, when completed, not to exceed the sum of $200,000, the building to be erected and the money expended under the direction and superintendence of the officer in charge of the State, War and Navy Department building.

H. R. 159. Whereas alcohol enters largely into the medicines which are prime necessaries to the sick and afflicted, and is now taxed to a burdensome extent. Therefore, that the tax on alcohol used for medicinal purposes be, and the same is hereby abolished.

H. R. 307. Provides compensation for the services of all volunteer female nurses who rendered service during the war, in the field or in hospital, under the direction and control of the medical authorities of the army, at the rate of twenty-five dollars for each month of service. That the nurses who have received twelve dollars per month shall have an additional thirteen dollars.

Ex. Doc. No. 24. Is a message from the President transmitting a communication from the Secretary of the Navy, inclosing a letter from Surgeon-General Wales, U. S. N., which recommends that a measure be adopted authorizing the representation of the United States at an international convention for the establishment of definite and uniform standards of examination for color-blindness and tests of visual acuteness. To this commission delegates should be sent to represent the several governments interested in the subject.

S. 31. Provides for the establishment of a Bureau of Animal Industry, to prevent the exportation of diseased cattle, and the spread of infectious or contagious diseases among domestic animals. In its sections it 1st, prohibits the transportation of diseased cattle; 2d, fixes the fine at from $100 to $5,000; 3d, provides for the organization of a Bureau of Industry with a chief, to be a competent veterinary surgeon, whose duty it shall be to investigate and report upon the number, value and condition of the domestic animals of the United States, their protection and use, and also inquire into and report the causes of contagious and communicable diseases among them, and the means for the preservation and cure of the same, and to collect such information on these subjects as shall be valuable to the agricultural and commercial interests of the country. The National Board of Health is required to render all necessary aid for this purpose, and, further, two commissioners are to be employed—one a practical stock-raiser, and one an experienced business man. They are to be paid at the rate of $10 per diem., with all necessary traveling expenses while engaged in the performance of their duty. The salary of the chief of Bureau to be $3,000 per annum; and a clerk is to receive $1,800 per annum. 4th. Special investigations of pleuro-pneumonia, or any contagious or communicable disease, to be made to control specially its influence upon the exportations of live stock. 5th. Is a further definition of laws for this purpose. 6th. Requires the Commissioner of Agriculture and the National Board of Health to prepare rules and regulations for the speedy and effectual suppression and extirpation of such diseases, and to invite State and Territory authorities to coöperate in their execution and enforcement. 7th. Makes $50,000 immediately available. 8th. Gives explicit directions to the Commissioners of the District of Columbia for the control of such diseases occurring within the District; and Section 9th makes it the duty of the U. S. District Attorney to prosecute all violations of the act.

S. 338. Appoints Dr. A. Sidney Tibbs, of Leesburg, Virginia, now an acting assistant surgeon, to the position of assistant surgeon in the U. S. Marine Hospital Service, without regard and in addition to the number now authorized by law for such service.

S. 81. Revokes the honorable discharge, June 17, 1870, of Assistant Surgeon Benj. F. Pope, U. S. A., and considers him as having been continuously in the service, and confirms his relative rank and title.

S. R. 6. Provides for the payment of fees to examining surgeons of pensions for 1883 and 1884.

CRAWFORDSVILLE, IND., DEC. 14, 1883.

EDITOR OF THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION:

The article entitled "Retention of Placenta After Delivery in Uterine Pocket," on page 649, issue of Dec. 8, 1883, of your journal, raises an interesting question as to the causes of uterine pockets. I have seen cases where the entire placenta was retained after the delivery of a child by the breech, the uterus contracting down and around until it presented a regular gourd shape, and it was with difficulty I could pass my hand through the portion corresponding to the handle of the gourd to remove the placenta, which I would not find unduly adherent, but seemingly grasped in the contracted walls of the uterus. My theory was, that the head of the child pressing upon the placenta furnished the necessary resistance to prevent that portion of the uterine wall covering

the placenta from contracting and throwing the placenta off. Without the support furnished by the pressure of the child's head, the placenta would furnish much less resistance. Also, in normal presentations, the buttocks or feet of the child might furnish pressure enough to keep a part of the placenta from being thrown off, and cause what Prof. Herrgote so clearly sets forth when he says, "but that it rather results from the non-contraction of that portion of the uterus upon which the placenta was attached, and which was afflicted with inertia, while the remaining portion of the uterus contracted, thus being passively distended over its contents and thinned in its walls, becoming a true hernial pouch on the uterine surface, the constriction to which became more and more pronounced as the body of the uterus diminished in size."

Thanks to Indiana not having a law regulating the practice of medicine, I was called a short time ago to see a lady who had had a quack attend her in her confinement, some 24 hours before my visit. She had been delivered of a healthy child at full term, and I was told it was a head presentation. The placenta being retained, the doctor (?) (who by his advertising sociability and liberality amongst our fun loving part of the community, does a big practice) pulled his coat off. He then placed his patient in the knee-chest position, and introduced a cylindrical glass speculum, and with a pair of uterine dressing forceps removed shreds of the membranes, keeping her in this position one hour and a half. She was then allowed to rest six hours, when he emptied the vagina of blood clots and repeated the picking process—making three hours the woman was kept in that position. When I arrived, the doctor (?) showed me a chamberfull of clotted blood, shreds of membrane, and the cord, and told me that was the entire afterbirth, and advised that the patient be not disturbed. I introduced my hand into the uterus, and detached all the placenta except about as much as a man could grasp in one hand, on the edge, which was firmly grasped by a uterine pouch. By passing first one and then two fingers up into the pouch, I succeeded in removing the entire placenta, much to the surprise of the friends of the patient and the chagrin of the doctor (?) May God speed the day when our women will not be exposed to such dangers —I mean exposed to such doctors (?)

Yours truly,

T. F. LEECH, M.D.

EDITOR JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION:

In your issue of Dec. 15, brief reference is made to a suggestion of Dr. S. C. Gordon, of Maine, that stenographic reports of the discussions held in the various Sections at the annual meetings be provided for.

Such a provision, I feel sure, would well repay the cost. It might be advisable to have the reports edited, either by the editor of the JOURNAL or a proper committee; though even this, probably, should not work a too rigid trimming of matter.

Society reports, to many physicians, constitute the most interesting portion of a medical periodical. Therein are found the prevalent views upon present and living topics—a kind of clinical discussion, we might almost term it.

Often must one regret, when a subject of interest is being handled by some of the weightiest men of the profession, that most of the valuable thoughts are uncollected, running to waste, we may say, for want of competent record.

Many of our best physicians fail, in the rush of work, to write out the observations they are constantly making upon the subjects of the day; but the discussion once sprung, they do not hesitate to engage in it. A stenographer, from this cause, could catch for us some of the very best thoughts developed by our annual gatherings.

Respectfully,

JNO. THAD. JOHNSON.

Atlanta, Ga., Dec. 29, 1883.

NECROLOGY.

SAULSBURY, GOVE, M.D., was born in Mispillion-neck, Kent Co., Delaware, May 29, 1815; died at his residence in Dover, July 31, 1881. He was the son of William Saulsbury, a man much respected and honored by his fellow citizens. His mother, Margaret Saulsbury (nee Smith), was the daughter of Capt. Thomas Smith, a lady of sound mind and Christian character.

There were born to them five children, James, William, Willard, Gove and Eli, of whom two yet survive,—Willard, formerly U. S. Senator from Delaware (now Chancellor), and Eli, at present U. S. Senator.

After an academic education, Gove studied medicine, and was graduated in the University of Pennsylvania in 1842. Subject of his thesis: Rheumatism. He commenced the practice of his profession in Dover, Delaware, and acquired an extensive professional business, which he retained to a considerable extent; even when his health was much shattered, he attended to it with great fatigue.

Dr. Saulsbury was an active member of the State Medical Society, and was honored with its highest offices. He was one of the original members who organized in 1846 the American Medical Association. Of these worthies but few now survive.

For 20 years he adhered closely to his profession, when he was elected to the State Senate, of which he afterwards became speaker, and *ex-officio*, Governor of the State on the death of Governor Cannon. In 1866, at the expiration of that *pro tempore* term, he was elected Governor, and in that office he exhibited the ability, decision, and controlling power of mind and presence, which contributed in a great degree to the influence which he continued to exercise in the State during his life.

His efforts in the cause of education were chiefly through the agency of the Wilmington Conference Academy of Dover, of whose Board of Trustees he was President from the time of its organization until his death.

As a member of the Methodist Episcopal Church he exercised so marked an influence, and his interest in its welfare was so appreciated, that he was selected to represent one branch of that church in the General Council of Methodism recently held in London, but which his death anticipated.

Dr. S. was much respected in the community in which he lived. A social and agreeable neighbor, a kind friend to the poor, warm in his attachments, and a devoted and affectionate parent; he has left behind him in his own city and State very many who will hold his memory dear while life lasts.

His wife was the daughter of Thomas Smith; their family consisted of five children, Margaret, Olivia Smith, Gove, jun., Rosa and William. The first three died young; Rosa, a lovely girl of 23 years of age, was taken away suddenly by death; William alone survives. The shock of the death of Rosa was too great for Mrs. Saulsbury's feeble health, and she soon followed her to the grave. Dr. Saulsbury was thus left alone with his son; to him the flavor of life had departed, and trials and disease soon did their work, and laid him beside so many of those dear to him in "the narrow house appointed for all the living."

L. P. Bush, M.D., of Delaware.

Williams, Lewis, M.D., was born in Pomfret, Connecticut, A. D. 1815. He died in his native town June 22, 1881, aged 65, of cerebral meningitis, with hæmorrhage upon the surface of the brain.

He entered Amherst College at the age of 19, but was obliged to discontinue his studies during his second college year, on account of ocular disease.

Upon recovering his health he commenced the study of medicine, and received the degree of M.D. from Harvard Medical College A. D. 1842.

He began the practice of his profession the following year in his native town, where he lived and labored forty years, winning the esteem and respect of all who knew him.

The same year that he settled in Pomfret he married Clara C. Baldwin, of Woburn, Mass., who survives him. This union was a very happy one. Mrs. Williams is spoken of by one who knows her well as "a woman of culture and Christian character. She was an inspiration to him in all his best endeavors, and made his home everything that the word can express, even in its highest and purest sense. Their hospitality was unbounded, yet in spite of the cares incident thereto, this ever active and tireless woman found time to assist her husband in much of his professional work, and he was proud to accord to her a large share in all his honors."

Dr. Williams was an active member of the Windham County Medical Society, the Connecticut State Society, and a permanent member of the American Medical Association since 1855. He was one of the Examining Committee of the Medical Department of Yale College, one of the quarterly visitors appointed by the State to the Retreat for the Insane at Hartford, and one of the Trustees of the State Normal School. He never sought public office, but devoted himself exclusively to the duties of his profession.

He was, however, much interested in the cause of education, and ever ready to do all in his power to assist all the educational interests in his town, county or State.

He was a man of pure character, strictly conscientious in all he did, and deeply impressed with the dignity and responsibility of his profession.

He was also a high-minded, whole-souled, generous citizen of broad culture, as well as a skillful, bold and careful physician. He loved the truth, and therefore detested quackery in all its forms. He was a diligent student to the end of his life, and fully up with the advance of the times.

He possessed in a large degree the confidence of his professional brethren, and his counsels were ever in demand by them near and far.

These calls from his associates, combined with the labors of a very extensive private practice, made his duties numerous and his life one of constant care. Still, although often oppressed with physical fatigue, his spirit was ever ready and willing to work for the benefit of his fellows, and his interest in his chosen profession never diminished.

The news of his death came unexpectedly to his large circle of friends and patrons, and was everywhere received with expressions of the sincerest regret.

The funeral services were held at the Congregational church at Pomfret, of which the doctor was long a consistent and prominent member. The occasion was one of universal sorrow, when all classes in the community, where he was born, lived and died, bore testimony of their love and respect for the good, pure, generous, wise friend and counselor who had been called from them forever.

Chas. H. Pinney, M.D.

Derby, Connecticut.

Whereas, The messenger "Death" has claimed as one of its victims our worthy and esteemed fellow member and ex-president, Dr. James Kerr.

Resolved, That we, the members of the Pittsburgh L. S. Medical Society, attest our sincere sorrow at the death of Dr. Kerr, and our high appreciation of his eminent attainments as a physician and surgeon.

Resolved, That as a society and individual members we shall keenly miss his genial features, his earnest sympathizing friendship, as well as his wise, efficient counsel.

Resolved, That in his death the community has lost a good citizen and a zealous, skillful and painstaking physician.

Resolved, That we extend to the family of deceased our heartfelt sympathy.

Resolved, That a copy of these resolutions be spread upon the minutes of this society, and one be sent to the family of deceased.

John M. Duff,
A. G. Case,
J. D. Thomas,
A. D. Brewster,
Committee.

Pittsburgh, Pa., Dec. 26, 1883.

THOMAS, J. R., M.D., of Bay City, Michigan, was born at Potter, Gates Co., N. Y., Oct. 17, 1827; died at his residence in Bay City, April 29, 1883 In youth, as is common with farmers' sons, he engaged in all the labors and duties of farm life. After acquiring a fair preliminary education, he entered the office of Dr. Charles H. Hoyt, of Potter, as a student of medicine and surgery. He graduated with honors at the Geneva Medical College, at that time one of the foremost medical schools in the State of New York. Soon after receiving his diploma he settled at Ellery Center, Chatauqua county, N. Y., for the practice of his profession. While there he was united in marriage with Emma Hilburt, of that locality, his present widowed wife.

In 1861 he entered the service of the United States as Assistant Surgeon to the 112th New York infantry, and went to the seat of war in North Carolina. After about one year he resigned his position, came to and settled n Bay City, where he has since practiced his profession very acceptably to the general public.

His affiliations with the profession of the State have been very cordial. In addition to his membership with the local societies of his own and adjacent counties, he was a member of the State Medical Society, having been one of its Vice-Presidents, member of the Judicial Council, a delegate to the American Medical Association, (of which he was a permanent member) and also President of the State Medical Society; he had also served two years as a member of the Board of Counselors with the Detroit Medical College. In all of these varied positions he had discharged the incumbent duties with credit and fidelity. He leaves a family consisting of an amiable and accomplished wife and two sons, the eldest of whom is now the editor of the *Jefferson* at Cairo, in this State, and the younger is now a sergeant in the regular service, and stationed at Fort Mead, in Dakota. The many and varied professional stations which the doctor was called to occupy during his life time sufficiently indicate his thorough accomplishments as a doctor of medicine, and his loss will nowhere be more keenly felt than by his numerous patrons.

The general public will attest fully the genial character of his social qualities, and his professional brethren, wherever known, will duly estimate their own bereavement.

His remains were taken to his old home in New York State.

At the meeting of the Board of Counselors of Detroit Medical College, and also of the State Medical Society, following the death of Dr. Thomas, members of both bodies gave expression to their estimate of the high character and sterling worth of Dr. Thomas, of his honorable professional bearing, and integrity and purity of life. Resolutions were adopted expressive of his services to medical science, of the loss to the profession and to those organizations to which he gave strength, and of sympathy to his family. H. TUPPER, M.D.

Forwarded by Dr. W. F. Brisky, of Mighigan.

SWEENEY, W. H., M. D., died at Red Wing, Minn., August 12, 1882, in the 64th year of his age.

Dr. Sweeney was born in Wilson, Pa., Dec 18, 1818, and began his education in the public schools. His father being a practical printer, and editor of a country paper, he early acquired a taste for literary pursuits, and became a ready writer. In 1836 he removed to Illinois, and for the next ten years worked hard on a farm and in a country printing office. In 1847 he began the study of medicine, and soon after came to St. Paul, Minn. Graduating at Rush Medical College, Chicago, in 1857, he returned to St. Paul, but the following year moved to Red Wing, Minn., where he finally located, and became the trusted physician of that beautiful young city. He was true and good in every walk of life, and when he died the expression of sorrow universal showed how he was honored.

He was a careful observer, and prepared many valuable papers for the medical journals and for the Minnesota State Medical Society, of which he was at one time President.

His views on the subject of epidemics, their origin, their relation to each other, etc., were original and striking.

D. V. HAND, M. D:, of Minnesota.

VAN DYKE, RUSH, M.D., descended from an old and highly honorable family, whose records go back to the settlement of New York by the Dutch. He was born in Philadelphia on the 9th day of September, 1813, and was the son of Dr. Frederick A. Van Dyke, a noted practitioner, the private pupil of the celebrated Professors Rush and Physick. He died at his residence in New Brunswick, N. J., Sept. 25, 1882.

At an early age Rush Van Dyke entered the family of his uncle, the late Col. James Van Dyke, of New Brunswick, N. J., where he commenced his education, which was thorough and complete. He entered Queen's (now Rutgers') College Grammar School, May 9, 1823. In 1826 he became a member of the sophomore class of Rutgers' College. On account of his youth he retired among the freshmen in October of the same year, and graduated as A.B. in July, 1830, and as Master of Arts in 1833, being a prominent member of his class.

He chose the profession of his family for his vocation, and commenced the study of medicine, under the direction of his father, in October, 1830. He graduated from the medical department of the University of Pennsylvania in the spring of 1835, a far longer period than the great majority of students of the present day allow to elapse between their study of "the first bone" and the reception of their "blue-ribboned parchment."

Very soon after graduation he was appointed to and accepted the post of Hospital Surgeon—an arduous office—on the very extensive plantations in Cuba of the well-known firm of Messrs. Wright, Shelton & Co., in which situation, and in general practice in the vicinity, he remained between three and four years. During his residence in Cuba he perfected his knowledge of the French and Spanish languages and literature, and had enjoyed ample opportunities of observing disease in its most dangerous and rare phases, and of gratifying his desire of studying medicine as a science.

In 1838 he returned to Philadelphia and entered into general practice, where his skill and acquirements soon secured for him the position of medical adviser of many of the leading families. He was, soon after his return, elected to fill the Chair of Professor in the old Medical College on Fifth street, where he delivered annually for several years a series of instructive and exhaustive lectures upon Physiology and Medical Jurisprudence. In September, 1848, he was elected to the Chair of Materia Medica and General Therapeutics in the Philadelphia College of Medicine. An exceedingly able and practical valedictory address to the graduating class was delivered by him in March, 1848, and published by the class. The introductory address of the course of lectures in 1852 was delivered by him and published by the class. On the resignation of Prof. Mitchell in July, 1852, he was called to the Chair of Theory and Practice of Medicine in the same institution.

When the Rebellion broke out Dr. Van Dyke hastened to the aid of his country, and with the assistance of Col. Small was largely instrumental in raising the 26th regiment, Pennsylvania Volunteers, of which he was the Lieutenant-Colonel. The regiment served three years. He afterwards was in charge of the U. S. Medical Hospital at Beverly, N. J., where he was noted for the thorough manner in which he cared for the numerons victims of the war that were gathered there. After the close of the war and a brief residence again in Philadelphia, Dr. Van Dyke removed to New Brunswick, where he continued to reside till his death.

Dr. Van Dyke married Rebecca Beauvard Williamson (one of the daughters of the late M. Williamson, iron merchant of Philadelphia), in 1851, who survives him. They had no children. Throughout life Dr. Van Dyke pursued a characteristically independent course, which became the more marked in its closing years and which, in connection with feeble health prevented him from securing the active practice which his decided ability merited. He frequently wrote on medical subjects and on the passing events of the day. His writings, as well as his addresses, were clear, logical and dogmatic. Though generally exhaustive and sometimes lengthy, he never indulged in circumlocution, but used the plain Anglo-Saxon words that were sure to convey his meaning. One of the New Brunswick daily papers in commenting on his death says: "He was not at home in the practical and busy life of the age. He had but little care for the accumulation of money. Indulged in severe and caustic criticism upon the follies of the day, and freely expressed his opinion upon all charlatanry, whether in his own profession or out of it. For the last three years of his life Dr. Van Dyke has been in feeble health, due to chronic disease (intestinal) contracted during the exposure of the war. He was without doubt a man of great natural ability, and but for the absence of all ambition would have made a distinguished mark upon his times."

He was a member of the Middlesex County (N. J.) Medical Society after 1869, served as its President one year, and two years as its Secretary, and was frequently elected one of the delegates to the State Society. He was also a member and for some years an officer of the New Brunswick Historical Club. He was warmly interested in the affairs of Rutgers' College. He was in 1833 Secretary, and in 1871-72 the Vice-President of the Alumni Association. In the year 1868 he delivered the annual oration before the Association of the Alumni, on "the Philosophy and Educational Requirements of the Age," which was afterwards published by request of the Association and greatly admired as a masterly literary effort. In 1873 he was elected Permanent Chairman of the Standing Committee of the Alumni Association, and filled the position with satisfaction till his death. In a minute adopted at the meeting of the Committee held September 27, 1882, he is thus spoken of: "He was a friend of Rutgers' College, having a laudable pride in her history and growth. He was one of the most active members of this committee, and a faithful representative of the Alumni. He was a gentleman of culture and literary taste, frank and decided in his opinions, and in this minute we desire to record our sense of his loss to us. We have found him prompt and efficient in the discharge of duty, zealous in the cause of education, and ready to co-öperate with whatever might promote the prosperity of his Alma Mater."

D. C. ENGLISH, M.D.

Forwarded by Dr. R. A. Watson.

TUNSTALL, ROBERT B., M.D., born August, 1818, died suddenly at his home in Norfolk, Va., April 1, 1883. He was educated at Norfolk, and at Hampshire-Sidney College, Virginia. He graduated in medicine in March, 1842, at the University of Pennsylvania. His thesis was on Delirium Tremens. He then returned home and entered upon his professional career, in which he soon gained an eminent position, and maintained it for more than forty-one years. Dr. R. B. Tunstall was a man of splendid physique, and was actively engaged in the performance of his duties up to within a few days of his death. Resolutions of respect were passed by the Norfolk Medical Society April 3, 1883. This, and other notices of his life and professional labors, may be seen in the *Virginia Medical Monthly*.

F. D. CUNNINGHAM, M.D., of Virginia.

SURGEON-GENERAL OF THE U. S. ARMY.—The appointment of Robert Murray Surgeon-General, to fill the vacancy occasioned by the death of the late Surgeon-General Crane, has proved highly acceptable to all parties. His rank of Senior Surgeon on the list for promotion, his long, faithful and valuable services, both in times of peace and war, no less than the high order of his attainments, all conspire to render his appointment one eminently proper and satisfactory.

COLLECTIVE INVESTIGATION OF DISEASE.—We have received a supply of the memoranda and cards from the Committee of the British Medical Association, for the investigation of pneumonia, diphtheria, acute rheumatism, and chorea. Those whose names have been sent to this office have been furnished with the necessary memoranda and cards, but there are enough left to supply, at least, one hundred more.

MISCELLANEOUS.

TREATMENT OF GLAUCOMA BY STRETCHING THE EXTERNAL NASAL NERVE.—Dr. Badal has an article on this subject in the *Annales D' Oculistique*, in which he gives the results of 24 cases that have been operated on by him. After discussing the mode of operation, he calls attention to the formulated conclusions of M. A. Trousseau, a student of M. Abadie, and based upon 10 cases, which he accepts. They are in effect:

1. The elongation of the external nasal nerve is a very simple operation, and is not a serious one in its effects. It may, in many cases, be substituted for iridectomy, and particularly for sclerotomy, in the treatment of glaucoma.
2. It succeeds sometimes where these operations have failed.
3. It may often delay the necessity for a more serious operation, such as extirpation or enucleation, and perhaps dispense altogether with the employ of these extreme measures.
4. It can be readily submitted to by patients, as it can be tried without inconvenience, and in case of failure leaves a free field for operations that are practicable directly upon the globe itself.
5. It can be essayed during the prodroma of glaucoma.
6. It relieves quickly the paroxysms of pain in glaucoma, and often prevents their return.
7. It sometimes increases the acuteness of vision.
8. It diminished markedly ocular tension.
9. In case of a negative result with the nasal nerve, it is well to try one of the other sensitive nerves of the orbit.

PERIMACULAR SYPHILITIC RETINITIS.—Syphilis may set its mark on every coat of the eye. The retina may be the seat of a recurrent form of central retinitis as mentioned by Von Graefe. M. Dehenne now believes that there exists another variety of central retinitis, to which he has given the name of "perimacular." The characteristic lesion of this newly discovered kind of syphilitic retinitis appears in the likeness of a hæmorrhage into the yellow spot; but this appearance is the effect solely of contrast. The apparent redness is surrounded by an ill defined area of greyish aspect, and is due to œdema of the retina. The malady sets in rapidly, or after a few abortive attempts. It is a rare affection, and seems to attack only one eye. The treatment should be actively antisyphilitic, but the prognosis is grave; atrophy of the optic papilla may be originated by the disease. Cases seemed to do well under the influence of subcutaneous injection of nitrate of pilocarpin (two centigrammes) used, when possible, in the morning, the patient fasting.—*Lancet.*

Professor Burt G. Wilder, of Cornell University, will deliver the Cartwright Lectures for 1884 in New York City February 2, 4 and 6. The subject will be "Methods of Studying the Brain."

A reception to Dr. M. Josiah Roberts, of New York, was given on Thursday evening by Dr. William H. Daly, of Pittsburgh, in that city. Several of Dr. Roberts' professional brethren in New York, Philadelphia, Chicago, and elsewhere, together with a large number of Pittsburgh physicians, were invited to be present.

LIST OF CHANGES IN THE MEDICAL CORPS OF THE NAVY DURING WEEK ENDING DECEMBER 29, 1883.

Medical Director A. L. Gihon, to the Naval Hospital, Washington, D. C.

P A. Surgeon, Chas. W. Rush, U. S. S. Colorado, granted sick leave for three months.

NEW BOOKS.

Gross, S. W. A Practical Treatise on Impotence, Sterility and Allied Disorders of the Male Sexual Organs. Second edition. Revised. Philadelphia: H. C. Lea's Son & Co. 8vo. $1.50.

Hermann, L. Experimental Pharmacology; A Handbook of Methods for Studying the Physiological Actions of Drugs. Translated by Robt. Meade Smith. Philadelphia: H C. Lea's Son & Co. 12mo. Cloth. $1.50.

Art, l', de Donner des Soins aux, Nouveau-nés; Parl'Academie d'Hygiène Contre les Maladies du Premier Age et de la Mortalité des Nounissons. 8vo. 24 pp. Paris: Goupy et Jourdan.

Bacon, A. Traitement des Kystes de l'Ovaire par la Poesten. 8vo. 37 pp. Paris: Davy.

Gére, J. M J. Contribution a l'Étude de Certaines Formes de Persistance de la Membrane Pupillaire Simulant des Synéchies d'Origine Pathologique 4to. 56 pp. Lyon, Duc et Demaison.

Guiard, P. F. Du Rein Mobile. 8vo. 40 pp. Paris: Bailliere.

Guignard, C. Infanticides. Fautil Rétablir les Tours? 8vo. 30 pp. Tours: Mazereau. 1 franc.

Honat, L. T. Des Propriétes Physiologiques et Curatives du Culex Piprens de l'Hydrocotele Asiatica, et Pathogénésie Nouvelle de Viola Odorata. 18mo. 92 pp. Paris: Bailliere.

Jozan, E. et G. Traité Pratique des Maladies des Voies Urinaires et des Organes Generateurs de l'Hommes. Twenty-first edition. 8mo. xvi. 898 pp., 355 fig., et 16 planches. Paris: Marpon et Flammarion. 5 francs.

Larat. Notice sur les Applications Médicales de l'Électricité. 18mo. 36 pp. Paris: Delahage et Lecrosnier. 2 francs

Rodet, P. Manuel de Thérapeutique et de Pharmacologie. 18mo, viii. 730 pp. Paris: Laumereyns. 7 francs, 50.

Sèmené, E. Des Hallucinations de la Musculation; La Conquete du Microbe. 8vo. 24 pp. Vichy: Wallon.

Sunéty, L de. Traité Promatique de Gynécologie et des Maladies des Femmes Second edition. 8vo., viii. 994 pp., 181 fig. Paris: Doin. 15 francs.